HEALTH

HEALTH AND HUMAN SERVICES OVERVIEW

Summary of Mid-Year Reductions

In December, the Governor proposed mid-year reductions which contained significant policy changes and program reductions for health and human services programs. Specifically, the Administration proposed reductions of over $439 million (General Fund), including reversions, program reductions, fund shifts, and restructuring, for 2002-03 and over $1.5 billion (General Fund) for 2003-04.

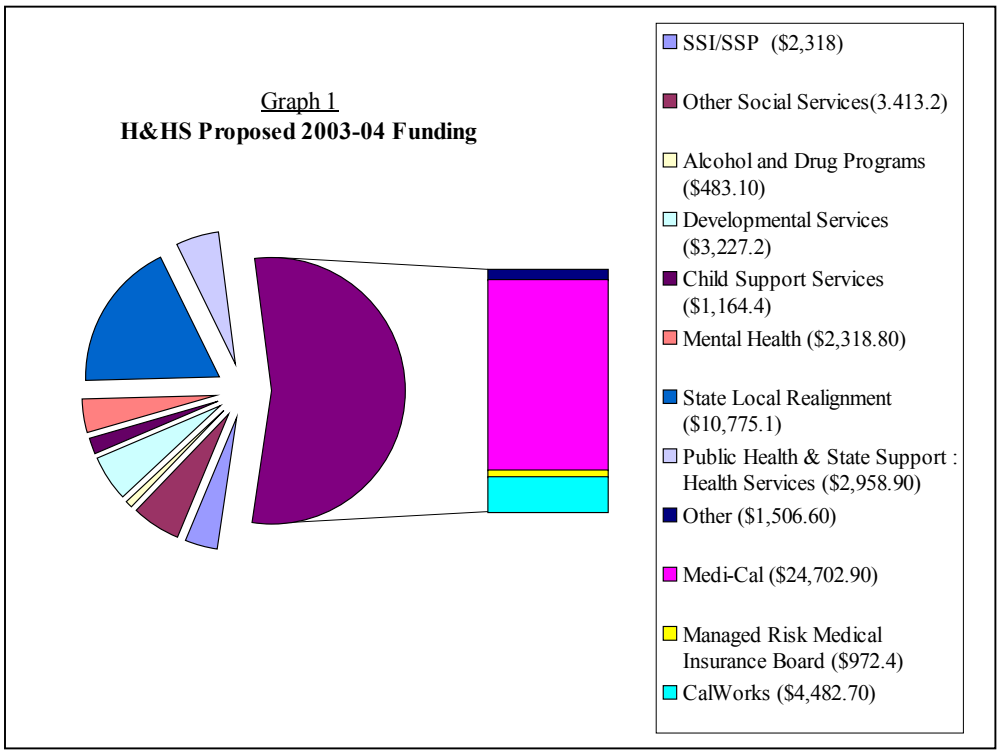
At the time of the publishing of this analysis, the Special Session mid-year reduction bill contained reductions of about $260 million (General Fund) for health and human services for 2002-03. Key items of reduction included the following:

- Suspending the SSI/SSP COLA for June 2003 for savings of $24.1 million (General Fund).
- Suspending the CalWORKs COLA for savings of $12.2 million (TANF federal block grant funds).
- Shifting $142.7 million in General Fund support for the purchase of services for consumers with developmental disabilities who are served by Regional Centers to federal fund support by expanding the Home and Community Based Waiver.
- Reducing the Prostate Cancer Treatment Program for savings of $10 million (General Fund).

The Legislature opted to defer decision on several of the Mid-Year Reductions to the budget year in order to afford the public, constituency groups and themselves with the opportunity to more thoroughly discuss and debate these substantive policy issues through the budget and policy committee processes.

Summary of Governor's Proposed 2003-04 Budget

The Governor's budget for health and human services proposes a total of $61.4 billion in combined state and federal funds as noted in the table. The General Fund portion is $15.1 billion, or 24.1 percent of the state's total General Fund expenditures.



The General Fund portion reflects a net decrease of $7.882 billion, or 34 percent, over the revised 2002-03 budget. The Administration's proposed General Fund decrease assumes (1) adoption of the Governor's Mid-Year Reduction adjustments, including adjustments which significantly affect the budget year and (2) a shift to the counties of $7.9 billion in General Fund expenditures for health and human services programs through the proposed Realignment.

The Governor's proposed budget for health and human services is built upon the following *key* assumptions:

- Shifts $7.9 billion in estimated health and human services program expenditures to the counties under a Realignment proposal (discussed below).
- Reduces Medi-Cal and non-Medi-Cal provider rates by a total of 15 percent for savings of $1.427 billion ($720.5 million General Fund). The savings level assumes adoption of trailer bill language to enact a ten percent reduction as of April 1, 2003, and an additional 5 percent reduction by July 1, 2003.
- Recommends legislation to suspend the annual cost-of-living-adjustment for SSI/SSP grants for savings of $372.3 million (General Fund). This proposed legislation would not affect the pass through of the federal SSI cost-of-living-adjustment.

- Recommends legislation to reduce the SSI/SSP payment standard to the minimum federally required level for savings of $662 million (General Fund). This proposal would reduce grants by 6.5 percent ($708 for individuals and $1,225 for couples), and would make 14,387 individuals completely ineligible for SSI/SSP and all associated services.

- Seeks legislation to reduce the maximum aid payment under CalWORKS by 6.2 percent for savings of over $235 million (TANF federal block grant funds). A family of three would receive $637 per month of eligibility. No General Fund savings are achieved through this proposal.

- Proposes legislation to rescind the 1931(b) Medi-Cal eligibility expansion (currently at 100 percent of federal poverty) and to reinstate the "100-hour a month work limit" for savings of $236 million ($118 million General Fund). These savings estimates assume that about 293,000 low-income, uninsured adults will not be eligible for Medi-Cal coverage.

- Seeks legislation to rollback the extension for the Aged and Disabled Medi-Cal eligibility category from 133 percent of federal poverty to the SSI/SSP income level for savings of $127.6 million ($63.8 million General Fund). This savings estimate assumes that 48,300 aged recipients and 20,540 disabled recipients are eliminated from Medi-Cal coverage. Under this rollback, the Medi-Cal income threshold would be $708 per month maximum for individuals and $1,225 per month maximum for couples. Individuals and couples above these income levels would have to pay a share-of-cost (i.e., spend down) in order to receive Medi-Cal coverage. Generally, the primary Medi-Cal benefit these individuals typically need is access to pharmacy services.

- Recommends legislation to reinstate the Quarterly Status Report effective April 1, 2003 and to change statute regarding the determination of Medi-Cal eligibility for savings of $10 million ($5 million General Fund) in 2002-03 and $170 million ($85 million General Fund) in 2003-04. These savings estimates assume that 33, 900 adults will be terminated from Medi-Cal coverage in 2002-03 and 193,123 adults are dropped in 2003-04.

- Eliminates eight Medi-Cal Optional Benefits effective April 1, 2003 and an additional ten benefits as of October 1, 2003 for savings of $126.5 million ($63.2 million General Fund) in 2002-03 and $723.7 million ($361.8 million General Fund) in 2003-04.

- Proposes to grant the Department of Developmental Services broad authority through legislation to institute statewide standards for the purchase of services for individuals with developmental disabilities who receive services through the Regional Center system for savings of $100 million (General Fund) in 2003-04.

- Assumes a savings of $51.8 million (General Fund) by requiring a 25 percent county share-of-cost for the federal penalty levied against California due to the state's delay in implementing an automated system for the collection of child support.

Each of these proposals as well as others are discussed in more detail below under each department.

Summary of Governor's Proposed Realignment

The proposed Realignment package consists of four components in the health and human services area (over $7.9 billion), plus a court security plan for the Trial Courts ($300 million). The Administration states that this proposed Realignment package would be *entirely* separate and distinct from the Realignment of 1991-92.

From a fiscal perspective the Administration assumes the following:

- General Fund Savings $8.154 billion

- State Operations Reductions ($3 million)
- Shift Proposition 99 Funds to counties $58 million
- Child Care COLA and Stage 3 Growth $64 million
    - **Cost to Counties $8.273 billion**
- Estimated Revenues from Tax Changes $8.334 billion
- Proposition 99 and Proposition 10 Backfill ($96 million) ($58 million is Proposition 99)
- Proposition 99 Funding $58 million
    - **Estimated Total Revenues $8.296 billion (Reserve of $23 million)**

The proposed new dedicated Realignment revenue would stream from the following sources:

- Sales Tax increase of one percent $4.584 billion
- Personal Income Tax (10-11 percent) $2.580 billion
- Tobacco Excise Tax ($1.10 increase) $1.170 billion
    - **Revenues from Tax Changes $8.334 billion**

For health and human services, the Administration proposes four components: (1) "Healthy Communities", (2) "Long-Term Care", (3) "Children and Youth", and (4) "Mental Health and Substance Abuse". These four components consist of the following:

- $2.7 billion for Healthy Communities, including a 15 percent share-of-cost (non-federal share) for Medi-Cal, a 50 percent share-of-cost for CalWORKS Employment Services and CalWORKS Administration, Food Stamp Administration, all of the community clinic programs, Cash Assistance for Immigrants, and numerous public health programs;
- $2.6 billion for Long-Term Care, including nursing homes and the In-Home Supportive Services (IHSS) Program;
- $2.3 billion for Children and Youth, including Child Care, Child Welfare Services, Foster Care Grants and Administration, Adoption Assistance, Kin Gap, and Child Abuse Prevention and Treatment; and
- $306 million for Mental Health and Substance Abuse, including local programs for drug and alcohol services (Proposition 36 funding), the Integrated Services for Homeless Adults, the Children's System of Care Program, and Drug Courts.

The Administration proposes trailer bill legislation for each of these components. At this juncture, the language is crafted broadly to express the Legislature's intent to enact legislation to (1) transfer the specified program and its non-federal share of expenditures, (2) maintain state oversight of said programs, and (3) become operative only if dedicated revenues are enacted for this purpose.

The proposal assumes that 2003-04 fiscal allocations to counties would be based on the proposed level of funding for counties for each of the programs, absent Realignment, in order to avoid program disruptions in the budget year. However for 2004-05, the Administration assumes that a single allocation would be made to counties based on a formula to be developed through discussions. As such, this would potentially serve as a type of "block grant" to the counties whereby the counties could conceivably shift funding across programmatic areas.

The Legislature may want to consider several factors when reviewing this proposal. First, any transfer of program and fiscal responsibility should be designed to assist both the state and counties in maximizing their service delivery responsibilities. If service delivery is maximized, the program participants will likely be better served and program efficiencies will more likely occur.

Second, the dedicated revenues provided for the program transfers should have a growth rate that is comparable with the anticipated growth of the program being transferred. If this is uncertain, a trigger mechanism should be considered in order to bring forth an expenditure or revenue discussion. The Realignment of 1991-92 included a "poison pill" provision for this purpose.

Third, the programs transferred should be programs that allow counties and constituency groups flexibility to craft innovative approaches that utilize community-based resources and services. Under the Realignment of 1991-92, mental health services were re-focused and shifted from a model heavily reliant on state hospital services to a model that now offers a broader array of community based options. Both fiscal incentives and policy flexibility were made available to allow for innovation and some experimentation.

Each of the four health and human services components are discussed in more detail below, under each applicable department.

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0530 California Health and Human Services Agency

The California Health and Human Services Agency (CHHS) administers the state's health, social services, rehabilitative and employment programs. The Secretary of the CHHS advises the Governor on major policy and program matters and oversees the operation of the agency departments. The purview of the CHHS includes the departments of Aging, Alcohol and Drugs, Community Services and Development, Developmental Services, Health Services, Mental Health, Rehabilitation, Social Services, and Employment Development, the Health and Human Services Data Center, the Office of Statewide Health Planning and Development, and the Managed Risk Medical Insurance Board, and the Emergency Medical Services Authority.

Through the Budget Act of 2001 and SB 456 (Speier), Statutes of 2001, the Office of Health Insurance Portability & Accountability Act (HIPAA) Implementation was created. This office resides within the CHHS.

The Office of HIPAA Implementation has statewide responsibility for the implementation of the federal HIPAA. The portion of HIPAA dealing with administrative simplification requires all billing and other electronic data transmissions to be standardized, as well as establishing new standards for the confidentially and security of this information. The office was established to direct and monitor this process.

Summary of Funding

The budget proposes expenditures of $5.9 million ($4.3 million General Fund), or an increase of about $800,000 over the revised 2002-03 budget, and 33 positions for the agency. Of this amount, almost $3.6 million and 11 positions are for the Office of HIPAA Implementation. The Office of HIPAA Implementation was reduced by $823,000 (General Fund) on a one-time only basis as part of the Governor's Mid-Year Adjustment proposal.

2400 Department of Managed Health Care

The purpose of the Department of Managed Health Care (DMHC) is to protect the public through administration and enforcement of laws regulating health care plans. The administration of these laws involves a variety of activities including licensing, examination, and responding to public inquiries and complaints. The program enforces its laws through administrative and civil action. Specifically, the DMHC licenses health care plans, conducts routine financial and medical surveys, and operates a consumer services toll-free complaint line.

The DMHC has three advisory boards--the Advisory Committee on Managed Care, the Clinical Advisory Board, and the Financial Standards Solvency Board. In addition, the Office of the Patient Advocate located within the DMC will help ensure that the needs of managed care consumers are heard and met.

Summary of Funding

The budget proposes total expenditures of $34.5 million (Managed Care Fund) and 297 personnel-years for the DMHC, which includes $2.1 million for the Office of Patient Advocate. This reflects a net increase of $1.9 million (Managed Care Fund) over 2002-03. The $1.9 million (Managed Care Fund) difference is primarily due to two items. First, a one-time only reduction of $558,000 and 14 positions was enacted as part of the Governor's Mid-Year Reduction proposal. Second, an increase of $834,000 (Managed Care Fund) is proposed for 2003-04 to reduce the department's salary savings level to seven percent. This will fund positions currently required to be kept vacant.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Health Care Service Plans	$30,615	$32,409	$1,794	5.9
Office of Patient Advocate	2,018	2,135	117	5.8
Total, Health Plan Program	$32,633	$34,544	$1,911	5.9

4120 Emergency Medical Services Authority

The overall responsibilities and goals of the Emergency Medical Services Authority (EMSA) are to (1) assess statewide needs, effectiveness, and coordination of emergency medical service systems; (2) review and approve local emergency medical service plans; (3) coordinate medical and hospital disaster preparedness and response; (4) establish standards for the education, training and licensing of specified emergency medical care personnel; (5) establish standards for designating and monitoring poison control centers; (6) license paramedics and conduct disciplinary investigations as necessary; (7) develop standards for pediatric first aid and CPR training programs for child care providers; and (8) develop standards for emergency medical dispatcher training for the "911" emergency telephone system.

Summary of Funding

The Administration proposes to eliminate the EMSA and transfer it to the Department of Health Services as part of the Mid-Year Reduction proposal. This proposed transfer would result in savings of $342,000 ($132,000 General Fund) due to staffing adjustments. The Legislature opted not to proceed with the transfer at this time and may have further discussion during future budget deliberations.

It should be noted that the Administration's budget assumes total funding of $14.9 million ($3.9 million General Fund) within the DHS, to reflect the proposed transfer, for all of the emergency medical services activities.

4250 California Children and Families Commission

The California Children and Families First Act of 1998 created this commission effective December 1998. The Commission consists of nine members—seven voting members and two ex-officio members. Three of the members are appointed by the Governor, two by the Senate Rules Committee, and two by the Speaker of the Assembly.

The commission is responsible for the implementation of comprehensive and integrated solutions to provide information and services promoting, supporting, and improving the early childhood development of children through the age of five. These solutions are to be provided either directly by the commission or through the efforts of the local county commissions.

Funding is provided through a 50-cent-per-package surtax on cigarettes, as of January 1, 1999, and an equivalent surtax on other tobacco-related products, as of July 1, 1999. These revenues are deposited in the California Children and Families Trust Fund. As required by the proposition, a portion of these revenues are transferred to the Department of Health Services to backfill for specified decreases in Proposition 99 funds (i.e., Cigarette and Tobacco Product Surtax Funds).

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Administrative Functions	$6,212	$6,273	61	1
Local Assistance—Counties	542,288	451,856	(90,432)	16.6
Mass Media Account	48,365	35,737	(12,628)	26.1
Education Account	55,246	29,775	(25,471)	46.1
Child Care Account	28,832	18,132	(10,700)	37.1
Research & Development Account	39,924	18,147	(21,777)	54.5
Unallocated Account	19,634	12,066	(7,568)	38.5
Total Expenditures	$740,501	$571,986	($168,515)	22.7

Summary of Funding

The budget proposes total expenditures of $572 million (special trust funds) for a decrease of $168.5 million over the revised current year. This reduction is due to a decline in revenues and a decline in carry-over funds which were available in the first year of implementation and have since been expended. It should be noted that the budget proposes to provide $62 million (Cigarette and Tobacco Surtax Funds) to backfill for the anticipated loss of revenue associated with the Governor's proposed realignment proposal.

The California Children and Families Commission funds must be used to supplement, not supplant, existing funds. The funds are distributed across accounts as required by Proposition 10. The funds are continuously appropriated pursuant to Section 30131.3 of the Revenue and Taxation Code.

The commission began funding initiatives using the various accounts in January 2000. These projects address recognized needs related to children's health care, child care and development, and family literacy.

4260 Department of Health Services

The goals of the Department of Health Services (DHS) are to (1) promote an environment that contributes to human health and well-being; (2) assure the availability of equal access to comprehensive health services using public and private resources; (3) emphasize prevention-oriented health care programs; (4) promote the development of knowledge concerning the causes and cures of illness and the means of

delivering health services to the public; and (5) assure economic expenditure of public funds to serve those persons with the greatest health care needs.

The budget proposes expenditures of $27.7 billion ($7.6 billion General Fund), or a decrease of $4.6 billion ($ 3.7 billion General Fund) over the revised 2002-03 budget. Of the total budget amount, $26.8 billion is for local assistance and $837.3 million is for state support. State support expenditures include funds for 5,674 personnel-years.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Program Source				
Health Care Services	$31,295,224	$26,636,486	($4,658,738)	(14.9)
Public and Environmental Health	886,314	964,516	78,202	8.8
State Mandated Local Programs	9	9		
State Administration	42,539	44,957	2,418	5.7
Emergency Medical Services Authority	--	14,939	14,939	100
Totals, by Program Source	$32,224,086	$27,660,907	($4,563,179)	(14.2)
Funding Source				
General Fund	$11,257,762	$7,555,551	($3,702,211)	(32.9)
Federal Funds	18,256,638	17,663,143	(593,495)	(3.3)
Other Funds	2,709,686	2,442,213	(267,473)	(9.9)
Totals, by Fund	$32,224,086	$27,660,907	($4,563,179)	(14.2)

The Medi-Cal Program

Summary of Funding

The entire Medi-Cal budget proposes expenditures of $27.7 billion ($7 billion General Fund, $3 billion Reimbursements from Counties). This reflects a *net* decrease of almost $3.6 billion (General Fund), or 33.9 percent less than the revised 2002-03 budget. This significant net reduction is attributable to several key factors, including the following:

- Transfers 15 percent of Medi-Cal benefit costs to the counties, along with a revenue stream, for savings of $1.6 billion (General Fund).
- Transfers fiscal responsibility, but not policy administration, of long-term care services to the counties, along with a revenue stream, for savings of $1.4 billion (General Fund).
- Reduces Medi-Cal and non-Medi-Cal provider rates by a total of 15 percent for savings of $1.427 billion ($720.5 million General Fund). The savings level assumes adoption of trailer bill language to enact a ten percent reduction as of April 1, 2003, and an additional 5 percent reduction (for a total of 15 percent) by July 1, 2003.
- Proposes legislation to rescind the 1931(b) Medi-Cal eligibility expansion (currently at 100 percent of federal poverty) and to reinstate the "100-hour a month work limit" for savings of $236 million ($118 million General Fund). These savings estimates assume that about 293,000 low-income, uninsured adults will not be eligible for Medi-Cal coverage.

- Proposes legislation to rollback the extension for the Aged and Disabled Medi-Cal eligibility category from 133 percent of federal poverty to the SSI/SSP income level for savings of $127.6 million ($63.8 million General Fund). This savings estimate assumes that 48,300 aged recipients and 20,540 disabled recipients are eliminated from Medi-Cal coverage.
- Proposes legislation to reinstate the Quarterly Status Report effective April 1, 2003 and to change statute regarding the determination of Medi-Cal eligibility for savings of $10 million ($5 million General Fund) in 2002-03 and $170 million ($85 million General Fund) in 2003-04. These savings estimates assume that 33, 900 adults will be terminated from Medi-Cal coverage in 2002-03 and 193,123 adults are dropped in 2003-04.
- Eliminates eight Medi-Cal Optional Benefits effective April 1, 2003 and an additional ten benefits as of October 1, 2003 for savings of $126.5 million ($63.2 million General Fund) in 2002-03 and $723.7 million ($361.8 million General Fund) in 2003-04.

Summary of Caseload

A. Description of Caseload. Presently about 6.5 million people, or one in five Californians, are eligible for Medi-Cal in any given month. According to the DOF, Medi-Cal provides health insurance coverage to 17.3 percent of Californians. Of the total eligibles about 45 percent, or 2.8 million people, are categorically-linked to Medi-Cal through enrollment in public cash grant assistance programs (i.e., SSI/SSP or CalWORKS).

Almost all Medi-Cal eligibles fall into four broad categories of people: (1) aged, blind or disabled; (2) families with children; (3) children only; and (4) pregnant women. Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category.

When eligibility is determined by the county, the county generally follows a hierarchy that would be most beneficial for the family. It should also be noted that there are about 170 categories or "aid codes" under which one may qualify for Medi-Cal, and that the Medi-Cal eligibility manual is over 1,800 pages long.

Generally, men and women who are not elderly and do not have children or a disability *cannot* qualify for Medi-Cal, no matter how low-income they are.

Over 1.5 million of the eligibles, or almost 25 percent of the total, are low-income persons who are aged (65 years or older), blind or disabled. Aged, blind and disabled individuals are eligible for Medi-Cal services through three different eligibility categories:

(1) SSI/SSP recipient and therefore categorically eligible for Medi-Cal (80 percent of the eligibles);

(2) "Medically Needy" individuals who are *not* receiving SSI/SSP and have incomes at 133 percent of poverty or below (15 percent of the eligibles); and

(3) Long Term Care individuals who are residing in nursing homes (4 percent of the eligibles).

Of these approximate 1.5 million eligibles, the disabled comprise about 61 percent of the total, the aged 37 percent and the blind almost two percent. It should be noted that over 60 percent of the aged or disabled Medi-Cal eligibles also have federal Medicare coverage. Since Medi-Cal is the payor of last resort, it is cost-beneficial for Medi-Cal to pay an individual's Medicare premium, as well as deductibles and copayments in order to shift certain medical expenditures to 100 percent of federal funding. On the

other hand, Medi-Cal provides on-going long-term care services and prescription drug coverage to these individuals whereas Medicare does not offer this costly coverage.

The "Medically Needy" category of Medi-Cal eligibility allows participation on a spend-down basis. This means that Medi-Cal will pay the portion of any qualifying medical expense that exceeds the person's "share-of-cost". The share-of-cost is the amount by which that individual's income or assets exceeds the applicable Medi-Cal limits.

About 3.8 million eligibles, or 61 percent of the total eligibles, are in uninsured families with children. These people are eligible for Medi-Cal through three different eligibility categories:

(1) CalWORKS-linked family and therefore categorically eligible for Medi-Cal (41 percent of the eligible families but only 25 percent of the total Medi-Cal eligibles);

(2) 1931 (b) families who are families *not* receiving CalWORKS, have two-parents and have incomes at or below 100 percent of poverty;

(3) Medically Needy families who are families *not* receiving CalWORKS, have incomes at or below 100 percent of poverty and must spend down to be eligible for Medi-Cal.

In addition to the above outlined categories, uninsured children are also eligible for Medi-Cal through distinct categories of eligibility established just for children and *not* linked to CalWORKS or SSI/SSP. These categories are generally based upon a family's income level, the age of the child and medical need (i.e., potential share of cost). A total of 435,000 children are estimated to be eligible in 2003-04 through the following categories:

(1) The 100 percent of poverty program provides coverage for children aged 6 though 18 years (148,00 estimated children);

(2) The 133 percent of poverty program provides coverage for children aged 1 through 5 years (132,000 estimated children);

(3) The Medically Indigent program provides coverage for children under age 21 who are in intact families where the parent(s) are employed (155,000 estimated children).

Uninsured pregnant women with family incomes at or below 200 percent of poverty are also eligible for Medi-Cal. Depending upon several eligibility factors, pregnant women can be covered under several of the above reference eligibility categories. Based on the latest data available, there were over 224,000 Medi-Cal deliveries in 2000.

B. Caseload Estimate For Budget Year and Affect of Eligibility Proposals. The revised caseload for 2002-03 of 6.5 million eligibles is 9.5 percent above the revised 2001 Budget Act level. However due to the Administration's proposed reductions in eligibility, the budget assumes a total of less than 6.3 million eligibles for 2003-04, for a *net* reduction of 209,000 eligibles, or 3.2 percent less from the revised 2002-03.

The Administration proposes five key policy changes which if enacted, would significantly reduce Medi-Cal eligibility. Specifically, these proposals include:

- Rescinding the 1931 (b) eligibility category to eliminate about 293,000 people;
- Reinstating the Quarterly Status Report to eliminate about 193,000 people;
- Rolling back the Aged, Blind and Disabled Program from 133 percent to 100 percent of poverty to eliminate almost 69,000 people;

- Establishing new standards for counties to make Medi-Cal redeterminations to eliminate about 563,000 people in 2003-04 due to making timely redeterminations; and
- Eliminating the second-year of availability for Transitional Medi-Cal coverage to eliminate about 1,800 people from coverage.

These proposals are discussed in further detail under the "Issues" section below.

Summary of Reductions

- Transfers 15 percent of Medi-Cal benefit costs to the counties, along with a revenue stream, for savings of $1.6 billion (General Fund).
- Transfers fiscal responsibility, but not policy administration, of long-term care services to the counties, along with a revenue stream, for savings of $1.4 billion (General Fund).
- Reduces Medi-Cal and non-Medi-Cal provider rates by a total of 15 percent for savings of $1.427 billion ($720.5 million General Fund) in 2003-04. The savings level assumes adoption of trailer bill language to enact a ten percent reduction as of April 1, 2003, and an additional 5 percent reduction (for a total of 15 percent) by July 1, 2003. The Legislature did not adopt the current year reduction.
- Proposes legislation to rescind the 1931(b) Medi-Cal eligibility expansion (currently at 100 percent of federal poverty) and to reinstate the "100-hour a month work limit" effective April 1, 2003 for savings of $12.4 million ($6.2 million General Fund) in 2002-03 and $236 million ($118 million General Fund) in 2003-04. These savings estimates assume that about 293,000 low-income, uninsured adults will not be eligible for Medi-Cal coverage in the budget year. The Legislature did not adopt the current year reduction.
- Proposes legislation to rollback the extension for the Aged and Disabled Medi-Cal eligibility category from 133 percent of federal poverty to the SSI/SSP income level for savings of $127.6 million ($63.8 million General Fund). This savings estimate assumes that 48,300 aged recipients and 20,540 disabled recipients are eliminated from Medi-Cal coverage.
- Proposes legislation to reinstate the Quarterly Status Report effective April 1, 2003 and to change statute regarding the determination of Medi-Cal eligibility for savings of $10 million ($5 million General Fund) in 2002-03 and $170 million ($85 million General Fund) in 2003-04. These savings estimates assume that 33, 900 adults will be terminated from Medi-Cal coverage in 2002-03 and that 193,123 adults are dropped in 2003-04. The Legislature did not adopt the current year reduction.
- Eliminates eight Medi-Cal Optional Benefits effective April 1, 2003 and an additional ten benefits as of October 1, 2003 for savings of $126.5 million ($63.2 million General Fund) in 2002-03 and $723.7 million ($361.8 million General Fund) in 2003-04. The Legislature did not adopt the current year reduction.
- Proposes legislation to establish standards for counties to meet regarding Medi-Cal redeterminations and assumes that because of these new standards, 563,135 Medi-Cal recipients will be terminated from enrollment for savings of $388 million ($194 million General Fund).
- Eliminates the supplemental payment to long-term care facilities that have a collective bargaining agreement to the compensation of care giver staff for savings of $25 million in 2003-04.
- Eliminates the second-year of coverage for people enrolled in the Transitional Medi-Cal Program which would terminate about 1,800 people from coverage and result in savings of $2 million (General Fund).

- Limits who can prescribe the drug Serostim (human growth hormone) to be only those physicians who are certified as being HIV specialists for savings of $7.5 million ($3.8 million General Fund).
- Proposes to implement new utilization and payment controls on various Medi-Cal services for savings of $76 million ($38 million General Fund).
- Eliminates funds of $6.2 million ($3.1 million General Fund) for the BabyCal Program which educates high risk pregnant women about the importance of early and ongoing prenatal care, the consequences of smoking, drinking and drug use during pregnancy, and the availability of programs to help women achieve healthy birth outcomes.
- Eliminates funds of $8.6 million ($3.1 million General Fund) for outreach for the enrollment of children in Medi-Cal and the Healthy Families Program. This adjustment would leave a total of $1.3 million ($650,000 General Fund) available to fund toll-free telephone lines which are used to provide program information to various interested parties, including potential enrollees.

Summary of Increases

- Implements the Childrens Disability Prevention Program (CHDP) Gateway effective July 1, 2003 by providing an increase of $231.5 million ($112.1 million General Fund) to provide for up to two-months of pre-enrollment coverage and to fund those who are Medi-Cal eligible. (It should be noted that the baseline CHDP budget is adjusted downward to reflect this shift to Medi-Cal.)
- Establishes an intergovernmental transfer program whereby public-operated Medi-Cal managed care entities, including County Organized Health Care Systems and the eleven Local Initiatives, would transfer funds to the state to be matched with federal funds to provide safety net providers with resources to strengthen their Medi-Cal provider networks. An additional $263.6 million in federal funds is anticipated to be received through this new mechanism.
- Appropriates $187.9 million ($94 million General Fund) for local assistance and $8.1 million ($4 million General Fund) for county administration to conform with the provisions of *Craig v Bonta'* which requires the state to provide Medi-Cal benefits to persons who are terminated from SSI/SSP effective June 30, 2002. In addition, the DHS must submit an implementation plan to the court pertaining to its planned compliance with Section 14005.37 of Welfare and Institutions Code regarding Medi-Cal eligibility redeterminations.
- Proposes legislation to implement a 6.5 percent provider "quality assurance fee" on Intermediate Care Facilities-for the Developmentally Disabled (ICF-DD) which would be used to obtain federal matching funds to provide a rate adjustment and offset a portion of General Fund expenditures.
- Augments by $31 million (federal funds) to provide a match to public funds (city, county or health district) provided as certification payments to Distinct-Part Nursing Facilities as allowed under existing statute.
- Provides the rate adjustment for hospital outpatient services as agreed to in the Orthopaedic Hospital Settlement for an increase of $207.2 million ($103.6 million General Fund) in the budget year. It should also be noted that the state paid its lump sum payment of $175 million (General Fund) in May 2002 but the $175 million in matching federal funds is still pending approval with the Centers for Medicare and Medicaid (CMS).
- Proposes an increase of $43.3 million ($21.6 million General Fund) to recognize a mid-year (January 2004) implementation of regulations pertaining to the nurse-to-patient ratio for hospitals as required in AB 394 (Kuehl), Statutes of 1999.

- Provides $1.846 billion ($923.2 million Intergovernmental Transfer Funds and $923.2 million federal funds) for payments to Disproportionate Share Hospitals (qualifying public and private hospitals) which reflects an increase of $46.8 million over the current year due to federal law which allows for a Consumer Price Index adjustment. It should also be noted that the state's "administrative fee" of $85 million which is used to offset General Fund expenditures for Medi-Cal is still in effect.

- Appropriates $72.4 million (federal funds) to continue to provide funds to qualifying teaching hospitals for services pertaining to inpatient clinical teaching and medical education activities that are provided to Medi-Cal recipients.

- Increases by $19.3 million ($9.6 million General Fund) funds for Medi-Cal services provided by Federally Qualified Health Centers and Rural Health Clinics to reflect the Medicare Economic Index increase as provided for in federal law.

- Provides a one-time increase of $33.4 million ($16.7 million General Fund) for county welfare department administrative costs.

- Increases by a total of $12.8 million ($6.4 million General Fund) to implement express lane eligibility in Medi-Cal for children as provided for in AB 59, Statutes of 2001 (Cedillo) and SB 493, Statutes of 2001 (Sher) including using information obtained from the National School Lunch Program as well as Food Stamps to make Medi-Cal eligibility determinations. Of this amount, $11.2 million is for health care services with the remaining amount to be appropriated for county administration.

- Augments by $1.3 million ($670,000 General Fund) to hire (1) a contractor to perform medical reviews associated with grievances involving medical issues and expedited state fair hearings, and (2) five Administrative Law Judges plus clerical support at the Department of Social Services to adjudicate an anticipated increase in state fair hearings due to recently enacted federal regulations pertaining to the Balanced Budget Act of 1997.

- Requests an increase of $1.2 million ($585,000 General Fund) for 12 positions for audit staff to recover overpayments relating to Medicare Cross Over billing issues.

- Augments by $896,000 ($448,000 General Fund) to hire nine positions to conduct various oversight activities related to proposed legislative changes which would establish standards for counties to meet regarding Medi-Cal redeterminations and other requirements.

- Increases by $954,000 ($239,000 General Fund) for 15 positions to increase estate recoveries in Medi-Cal. It is anticipated that these positions will generate $13 million in General Fund savings annually.

- Proposes an increase of $508,000 ($198,000 General Fund) to provide a cost of living increase to Los Angeles County for their licensing and certification contract.

- Requests an increase of $2.1 million ($707,000 Health Facility Citation Penalty Fund) for 29 positions to implement a new initiative to promote quality of care and quality of life for nursing home residents by implementing a statewide expansion of the Health Facility Consumer Assistance Center pilot project.

- Requests an increase of $1.6 million ($805,000 General Fund) for 19 positions to address staffing shortages in the Licensing and Certification--Complaint and Fingerprint Investigation Units.

- Augments by $266,000 (total funds) to fund three limited-term positions to implement pending changes to the Disproportionate Share Hospital (DSH) Program as a result of federal requirements,

including those to be imposed by the Office of Inspector General and the Centers for Medicare and Medicaid (CMS).

- Requests an increase of $259,000 (total funds) to fund three positions to provide assistance to schools relating to claiming reimbursements for Medi-Cal administrative activities and related matters.
- Proposes an increase of $930,000 ($232,000 General Fund) for three positions and a contract to complete development of the Enhanced Medi-Cal Budget Estimate Redesign (EMBER) project.
- Provides $211,000 ($53,000 General Fund) for three positions to increase revenues through personal injury recoveries.
- Proposes $230,000 ($115,000 General Fund) for three limited-term positions to continue the Long-Term Care Integration Pilot Program.
- Appropriates $614,000 ($283,000 General Fund) to fund a contract and four limited-term positions to conduct compliance activities, craft regulations and complete an independent assessment regarding a pilot Medi-Cal Waiver program pertaining to continuous skilled nursing as enacted in AB 359 (Aroner), Statutes of 1999.
- Provides an increase of $149,000 ($75,000 General Fund) for two positions to implement the ICF-DD quality assurance fee program.
- Provides $87,000 (total funds) for a position to implement and administer AB 915 (Frommer), Statutes of 2002 to provide supplemental reimbursements to Adult Day Health Care Centers and acute care hospital outpatient departments owned by specified public entities that provide services to Medi-Cal recipients.

Issues for the Medi-Cal Program

1. 15 Percent Transfer of Medi-Cal Benefit Costs to Counties. As part of the "Healthy Families" Realignment proposal, the Administration proposes to shift 15 percent (non-federal share) of Medi-Cal benefit costs to the counties for a savings of $1.620 billion (General Fund). The counties would use revenues obtained from newly proposed tax adjustments to fund this share of cost. As presently proposed the state would retain authority regarding eligibility criteria, benefits offered, reimbursement rate levels and all other policy aspects of Medi-Cal administration.

Medi-Cal is a complex program which is driven by federal law and regulation, case law and legal settlement agreements, state law and regulation, and trends in overall health care such as the absence of employer-sponsored coverage, continually rising health care costs and changes in the methods of medical practice.

Changes in federal Medicare policy can also significantly affect policy choices and expenditures in Medi-Cal. For example, Medi-Cal provides long-term care services and pharmacy benefits whereas Medicare does not. As such, many elderly and disabled individuals who are dually eligible for both programs obtain these benefits through Medi-Cal.

In reviewing this proposal within the context of the principles established in crafting the Realignment of 1991-92, it does not appear to be a constructive fit. An entitlement program with the complexities inherent in the Medi-Cal Program does not afford local government with the opportunity to identify innovative ways to recast the program or even to shift expenditures to more of a community-based, lower cost model of service, as was effectuated under the mental health program Realignment of 1991-92. It is very unlikely that discretion of any modicum would be granted to counties due to the need to maintain

certain federal requirements, particularly the need to ensure that Medicaid (Medi-Cal) recipients receive a like level of service no matter where they live in the state (i.e., the statewideness factor).

Question also arises as to the reliability of the revenue stream to sustain a 15 percent share of Medi-Cal benefit costs even in the near term. A recent study by the federal Centers for Medicare and Medicaid Services (CMS), as published in *Health Affairs*, shows that overall health care spending in the United States rose by 8.7 percent from 2001 to 2002. The major contributing factors sited were the rising cost of prescription drugs, hospital care and Medicaid expenditures, particularly for the aged, blind and disabled populations.

2. Realignment of Long-Term Care Nursing Homes to the Counties. As part of the "Long-Term Care" Realignment proposal, the Administration shifts the cost (non-federal share) of skilled nursing facility care to the counties for General Fund savings of $1.4 billion. This includes all skilled nursing facilities (freestanding as well as distinct-part facilities), but does not include Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). Federally mandated benefits such as pharmacy would remain the responsibility of the state for those eligible individuals residing in these facilities.

Generally, nursing home expenditures are primarily driven by the acuity of the patient, direct care staffing needs, the existing labor market, and quality assurance standards. Counties will have little, if any, control over these factors. This component of realignment suffers the same limitations as the proposal to shift 15 percent of the share of Medi-Cal costs to the counties. It does not offer local government the opportunity to identify innovative ways to recast the program or even to shift expenditures to more of a community-based model. It simply has the counties serve in a caretaker capacity with no where to go for program expenditures, except up.

Shifting expenditures for skilled nursing care to the counties runs contrary to recent sweeping changes enacted by the Legislature to make major reforms regarding quality of care issues, direct care nursing staff to patient ratios, and restructuring options for changing the existing Medi-Cal reimbursement rate methodology. Many of these reforms would be left in mid-stream or not completed at all if expenditures are shifted. Counties could be left in the untenable position of trying to fund program expenditures with no ability to modify policy.

In addition, it is unclear how the state's implementation of the United State's Supreme Court's decision in *Olmstead v L.C.* (527 US 581 (1999)) would be affected by this realignment proposal. Under Olmstead the court ruled, among other things, that an individual with a disability has a right to live in a community setting as long as certain conditions are met. This would include some existing residents of nursing homes. The California Health and Human Services Agency is presently crafting an Olmstead Plan, to be provided to the Legislature by April 1, 2003, in which options for meeting Olmstead needs are to be discussed. Therefore, it would be beneficial for the Legislature to review this plan in the context of this realignment proposal.

3. Reinstate Quarterly Status Reports (QSR). The Administration proposes legislation to reinstate the Quarterly Status Report (QSR) effective April 1, 2003 *and* to change statute regarding the determination of Medi-Cal eligibility. Savings of $5 million (General Fund) in 2002-03 and $85 million (General Fund) in 2003-04 are estimated for this action. These savings estimates assume that 33,900 adults will be terminated from Medi-Cal coverage in 2002-03 and that 193,123 adults are dropped in 2003-04. With respect to the mid-year proposal, the Legislature chose to deny it and to focus on the budget year.

Under the QSR process, families participating in Med-Cal only (non-cash aid) are required to complete a detailed form about income and other personal information *every* three months (quarterly), even if there is no change in the families circumstance. Medi-Cal coverage is discontinued if the form is not promptly returned.

The Budget Act of 2000 eliminated the QSR process in favor of a streamlined system whereby families are required to self report within 10-days of any change in circumstance (such as a change in income). Elimination of the QSR reduced administrative processing, maintained the families health care coverage, and simplified Medi-Cal to conform with the Healthy Families Program.

Prior to the elimination of the QSR, many Medi-Cal recipients were terminated from coverage even though they still qualified for services simply because they did not submit a QSR.

The Administration's proposed language would significantly erode existing statute (SB 87, Statutes of 2000) by deeming Medi-Cal recipients who fail to return the QSR as being uncooperative and automatically terminated from benefits. This aspect of the Administration's proposal goes beyond simply reinstating the QSR.

Chapter 1088, Statutes of 2000 (SB 87, Escutia), generally requires that in instances when Medi-Cal eligibility has been terminated on one basis, that a review must be conducted to determine if the individual is eligible for Medi-Cal under other circumstances. All avenues of potential Medi-Cal eligibility are to be reviewed to determine ongoing eligibility. It should be noted that under the Craig v Bonta' lawsuit, the court ruled in favor of the plaintiffs, and has, among other things, required the DHS to submit an implementation plan regarding compliance with Section 14005.37 of Welfare and Institutions Code regarding Medi-Cal eligibility redeterminations.

Reinstatement of the QSR would achieve savings by terminating adults from Medi-Cal who are still likely eligible for Medi-Cal but simply did not return the QSR. The majority of recipients affected by this change would be adults (non-cash aid) enrolled in Medi-Cal managed care plans. However as discussed below, children could also be effected.

There are several concerns with this proposal. First, these Medi-Cal recipients are very low-income wage earners—usually working people who have left CalWORKS and need medical coverage. Their circumstance is not likely going to change significantly and if it does, the recipient is required to report a change within 10 days. In addition, county eligibility offices can and often do monitor changes in Medi-Cal recipients' earnings using the state's automated wage reporting system; therefore, program eligibility can be checked prior to a recipients annual re-determination period.

Second, individuals dropped from Medi-Cal for not returning a QSR will likely seek medical assistance at county indigent health clinics or the emergency room. Safety net hospitals would lose Medi-Cal revenues and likely have to provide coverage to more uninsured.

Third, a key concern with this proposal is its interaction with the Administration's proposal to eliminate the 1931 (b) Medi-Cal eligibility category. If a Medi-Cal recipient (adult, non-cash aid) does not return their QSR and is dropped from Medi-Cal, they likely will *not* be able to re-apply for Medi-Cal due to the elimination of the 1931 (b) category. This issue is discussed further in item two below.

Fourth, elimination of the QSR was intended to reduce over time Medi-Cal Administration costs in order to make the program more efficient and effective. Over the past two fiscal years, county Medi-Cal administration has been reduced by $459 million ($229 million General Fund) to reflect several cost reductions. If the QSR is reinstated, counties will need substantially more funding in order to re-program computer systems, train eligibility workers, and hire additional staff to process the additional paperwork.

Fifth, it would severely erode existing statute (SB 87, Statutes of 2000) by deeming Medi-Cal recipients who fail to return the QSR as being uncooperative and automatically terminated from benefits. As such, these individuals would not have their eligibility status reviewed by the county, nor would they be eligible to receive Transitional Medi-Cal Program coverage even if they would otherwise quality (low-income) for the benefits.

Sixth, 37 other states allow parents participating in Medicaid to annually renew their coverage. In fact, a federal review conducted of California in 2000 expressed grave concerns that a significant number of Medi-Cal recipients were losing coverage because the QSR was not being returned. In response to this criticism, the Davis Administration noted that it was eliminating the QSR requirement to facilitate the retention of families.

Further, there could be *unintended* consequences for children if this proposal is adopted. Many families apply to Medi-Cal as a family unit (parents and children). Subsequently, unless county computer systems are modified to distinguish between family members who are subject to the QSR and family members who are not, children could lose their Medi-Cal coverage inappropriately through a processing error. This is a realistic concern since a federal review conducted in California in 2001 found numerous inconsistencies in the operation of Medi-Cal computer systems across counties. In addition, parents receiving a Medi-Cal termination notice may mistakenly believe that their entire family, including children, are being dropped from enrollment.

Pregnant women, CalWORKS-linked adults, and the aged, blind, and disabled Medi-Cal recipients are not affected by this QSR proposal.

4. Rescission of 1931 (b) Medi-Cal Eligibility. The Administration proposes legislation to rescind the 1931 (b) Medi-Cal eligibility expansion (currently at 100 percent of federal poverty) *and* to reinstate the "100-hour a month work limit". This proposal would limit eligibility to families with incomes up to about 61 percent of poverty (annual income of $11,041 for a family of four). With respect to employment, two-parent families would become *ineligible* for Medi-Cal if the principle wage earner works *more* than 100 hours a month (about 23 hours a week), no matter their low-income level.

The proposal assumes an April 1, 2003 implementation with savings of $12.4 million ($6.2 million General Fund) in 2002-03 and $235.9 million ($118 million General Fund) in 2003-04. These savings estimates assume that 58,578 adults will not be eligible for Medi-Cal coverage in 2002-03 and that 292,890 adults will not be eligible for Medi-Cal coverage in 2003-04. After full implementation, the DOF estimates savings of $985.1 million ($492.6 million General Fund) annually. With respect to the mid-year proposal, the Legislature chose to deny it and to focus on the budget year.

Here are examples of how Medi-Cal eligibility would be changed and made more complex under this proposal:

- Two-parent working families applying for Medi-Cal where the primary wage earner works *more* than 100-hours per month will no longer qualify for Medi-Cal at *any* income level.

- Two-parent working families applying for Medi-Cal where the primary wage earner works *less* than 100-hours per month, will be eligible for the 1931 (b) category if their incomes are under 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they would qualify for Medi-Cal under the Medically Needy category. If there income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.

- Single-parent families and those two-parent families where one is disabled can qualify for the 1931 (b) category if their incomes are below 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they qualify for the Medically Needy category. If there income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.

Families enrolled in Medi-Cal now (recipients) who rely on the applicant income test (families with unearned income, such as disability income) will only quality for the 1931 (b) category if their incomes are under 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they qualify for the Medically Needy category. If there income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.

The Budget Act of 2000 expanded eligibility for Medi-Cal to include families with income up to 100 percent of the federal poverty level. This action was in response to a federal Welfare Reform law change (Section 1931 (b) of the Social Security Act) which enabled states to grant Medicaid eligibility to anyone who would have met the income, resource and deprivation rules (such as children with an absent, decreased, incapacitated, or unemployed parent) of the AFDC Program as it existed on July 16, 1996 (date selected by Congress).

The concept behind this federal policy was to maintain health coverage for families that leave welfare for work, eliminate the incentive to be on welfare in order to receive health care coverage, and to make health care available for working, very low-income families.

The Administration's proposal would deny health care coverage through the Medi-Cal Program to hundreds of thousands of low-income, working families. These are families which are low-income, *not* receiving cash-assistance, and who need health care coverage because their employers do not provide it.

As illustrated by the eligibility examples provided above, this proposed policy change serves as a *disincentive* to work full-time, to maintain family unity, and to move off of CalWORKS. Many families would not qualify for Medi-Cal even though they meet the low-income test because they are working more than 100-hours a month. If they lose health care coverage, they can spiral back into CalWORKS and potential poverty. If desired, the 1931 (b) eligibility category could be reduced *without* reinstating the 100 hour a month work limit.

Children are also affected by this proposal. While the proposed changes are intended to make more parents ineligible for Medi-Cal, the fact is that the entire family loses coverage. The children would have to re-apply for eligibility under the Medi-Cal for Children Program (the 100 percent and 133 percent poverty programs).

This proposal also interacts with the Administration's proposal to reinstate the Quarterly Status Report (QSR). If an existing 1931 (b) category recipient loses Medi-Cal because they do not return their QSR, they are dropped from Medi-Cal and likely would *not* be eligible for Medi-Cal due to the elimination of the 1931 (b) category. This is particularly true for those who are working more than 100 hours a month.

This proposal also affects a families eligibility for Transitional Medi-Cal services. Currently when a family loses 1931 (b) eligibility because their income goes above 100 percent of poverty, they can still potentially obtain up to two years of coverage. The purpose of this federal law for transitional services is to assist families to move into self-sufficiency. However, families in the Medically Needy category are not eligible for Transitional Medi-Cal services. Subsequently families with incomes above 61 percent of poverty who will no longer qualify for 1931 (b) but will qualify for the Medically Needy category will *not* be eligible for Transitional Medical services.

The proposal would also require some families to pay a share of cost each month in order to obtain their Medi-Cal health care coverage. Families currently enrolled in the 1931 (b) program have no share of cost. Under the Administration's proposal families with incomes above 75 percent of poverty would have to pay a share of cost.

The proposal would also add additional complexity to Medi-Cal eligibility determinations. Changes to county computer systems, as well as county eligibility worker training, would be needed to implement this proposal. However the Administration's cost estimate does not take this into consideration.

5. Eliminates 18 Optional Medi-Cal Benefits. The Administration proposes legislation effective April 1, 2003 to eliminate eight Medi-Cal Optional Benefit categories as part of the Governor's Mid-Year Reduction process for savings of $126.5 million ($63.3 million General Fund). For the budget year, ten additional benefits are slated for elimination for a total of 18 benefits for savings of $723.7 million ($361.8 million General Fund). These reductions are outlined in the table below.

Optional Benefit Category	2002-03 Mid-Year Proposal (April 1, 2003) (General Fund Savings)	2003-04 Governor's Proposed (General Fund Savings)
Adult Dental Services	$48.5 million	$211.8 million
Medical Supplies (diabetic supplies, IV supplies, wound care, asthma supplies, contraceptive supplies)	12.9 million	54.3 million
Van Transportation		31.5 million
Hospice		13.7 million
Durable Medical Equipment		12.5 million
Optician and Laboratory Services		14.5 million
Optometry		9.2 million
Podiatrist	995,000	4.3 million
Acupuncture	666,000	2.9 million
Prosthetics		2.1 million
Hearing Aids		2.9 million
Psychologist	57,000	229
Chiropractor	100,000	399
Independent Rehabilitation Facility	5,000	23
Occupational Therapy	4,000	15
Physical Therapy		30
Orthotics		640
Speech and Audiology		728
TOTAL GF SAVINGS	**$63.3 million**	**$361.8 million**

Exempt from the proposal are services to children under 21 years of age and residents of long-term care facilities. Federal law precludes the elimination of these services from these individuals.

However, individuals with developmental disabilities would not be exempt from the Administration's proposal. As such, it is likely that Regional Centers would need to purchase these benefits for consumers at 100 percent General Fund expenditure, in lieu of obtaining partial matching federal funds. These costs have not yet been calculated by the Administration.

As noted above, the three categories of adult dental services, medical supplies and van transportation (i.e., non-emergency medical transportation) account for over 80 percent of the proposed savings. Denial of adult dental services, van transportation or certain medical supplies such as asthma supplies will likely result in increased emergency room visits for pain and other medical services and subsequently, result in additional costs.

In addition, there may be increased costs due to the delay in recipients receiving treatment and ultimately requiring more acute care services. For example, van transportation is primarily provided for dialysis patients. As such, the elimination of this benefit means that fragile dialysis patients could have renal failure for lack of transportation access.

Another example pertains to adult dental services. At the direction of the Administration, the Budget Act of 2001 added preventive periodontal services and treatment for pregnant women to the scope of Medi-Cal benefits because it saves money by decreasing neonatal intensive care services. It has been well documented that periodontal disease affects the embryo, often causing pre-term low birth pre-term low

birth weight babies. These services could *not* be provided if Adult Dental services are eliminated. For example, denial of some medical supplies or Adult Dental benefits may result in increased emergency room visits for pain and other medical services.

In lieu of eliminating these benefits, one could implement selective cost containment measures. For example, the adult dental benefit could be restructured to capitate the amount of service a recipient obtains.

It should also be noted that the DHS was given authority in the Budget Act of 2002 to contract for certain medical supply items which was estimated to save $9 million (General Fund) in 2002-03. It may be possible to include other medical supply items in this process to reduce expenditures and to even re-calculate how mark-up is determined for some incontinence supplies or related items.

Elimination of selected Medi-Cal Optional Benefits has been proposed on five prior occasions—1990, 1992, 1993,1994 and 1995. Even during these difficult fiscal times, the proposal was denied by the Legislature.

6. Reduces Medi-Cal *and* Non-Medi-Cal Rates by 15 Percent. The Administration proposes legislation to reduce *both* Medi-Cal *and* Non-Medi-Cal provider rates by 10 percent across-the-board effective April 1, 2003 to achieve savings of $479.3 million ($90.4 million General Fund) within the Medi-Cal Program for 2002-03, and by a total of 15 percent for 2003-04 to achieve savings of $1.428 billion ($720.5 million General Fund) within the Medi-Cal Program for 2003-04. The legislation would continue the reduction for three years through 2005-06 (ending as of July 1, 2006). This is the first time that an across-the-board rate reduction has been proposed.

For Medi-Cal providers, the rate reduction **includes** nursing home facilities, Intermediate Care Facilities for Developmentally Disabled (ICF-DD), physician services, pharmacy, dental services, managed care plans, home health, medical transportation, and other medical services. This is the first time that nursing home facilities have been included in a rate reduction.

The rate reduction also includes Non-Medi-Cal programs, including the California Children's Services (CCS) Program, the Family Planning, Access, Care and Treatment Program (Family PACT), the State-Only Family Planning Program, the Genetically Handicapped Persons Program, and the Breast and Cervical Cancer Early Detection Program. The proposed trailer bill legislation would also provide the Director of the DHS authority to identify in regulations *other* programs in which providers shall be paid rates of payment that are identical to the rates paid under Medi-Cal.

The following table summarizes the rate reduction affect to Medi-Cal Programs for 2003-04. (The Non-Medi-Cal programs are discussed under the Public Health and Environmental Health Section, below.)

Medi-Cal Service Category	2003-04 Governor's Proposed (July 1, 2003) (15 percent) (General Fund Savings)
Nursing Home Facilities (including ICF-DD)	$253.2 million
Managed Care Plans	211.5 million
Physicians Services	76.6 million
Other Services (adult day health, hospice, hearing aids, AIDS waiver, and others)	46.3 million
Other Medical Services (podiatry, occupational therapy, acupuncture and others)	30.1 million
Pharmacy Services	23.7 million
ICF-DD Facilities	30.4 million
Dental Services	23.8 million
Home Health	13 million
Early Periodic Screening Diagnostic and Treatment (EPSDT) Services	2 million
Medical Transportation	9.8 million
TOTAL SAVINGS	**$720.5 million**

Exempt from the reduction are: hospital inpatient services, hospital outpatient services, state operated facilities—i.e., Developmental Centers and State Hospitals for the mentally ill—, and Federally Qualified Health Centers/Rural Health Centers. Hospital inpatient services are exempt since the state negotiates inpatient services through the CMAC, and hospital outpatient services are addressed in the Orthopaedic Settlement Agreement. Federal law prohibits an across-the-board rate reduction for FQHC/RHC facilities since a cost-based or prospective payment system is used.

There is some evidence that the rates paid to providers could affect access to health care and the quality of care to patients. A recent national analysis of Medicaid physician rates by The Urban Institute concluded that physician fee levels affect both access and outcomes for Medicaid patients.

In the Budget Act of 2000, most services provided under Medi-Cal received rate adjustments. This action was not an across-the-board rate increase, but instead targeted services for which Medi-Cal physician rates were relatively low in comparison to the Medicare Program. Generally, other than annual adjustments for nursing home rates, there had not been a rate increase for most Medi-Cal services prior to the Budget Act of 2000 since 1986.

A Pricewaterhouse study completed last year found that, even after accounting for the rate increase provided in 2000, Medi-Cal rates continue to lag behind those of other purchasers of health care coverage in California. Another study released last year found that while the 2000 Medi-Cal rate increases were substantial, they collectively only brought the Medi-Cal provider rates from 58 percent to 65 percent of California's average Medicare payment rates.

Inclusion of nursing homes in this reduction may be particularly problematic due to staffing standards and wage requirements, federal regulations, and the industry's dependence on Medi-Cal payments (two-thirds of the over 1,500 homes depend on Medi-Cal reimbursement). In addition, a State Plan Amendment would be required since the federal government requires these rates to be developed on an annual basis through a methodology contained in the state's Medicaid State Plan.

7. Rollback of Aged, Blind and Disabled Medi-Cal Eligibility for Medically Needy. The Budget Act of 2000 extended "no cost" Medi-Cal eligibility to Aged, Blind and Disabled individuals with incomes up to 133 percent of federal poverty. These individuals have low-incomes but either do *not* qualify for, or choose not to participate in, the SSI/SSP Program. Currently, individuals can have income of up to $969 per month and couples can have income of up to $1,332 per month and qualify for "no cost" Medi-Cal.

The Administration proposes to roll this expansion back to cover only those eligibles with income up to the SSI/SSP income level or $708 per month for an individual (96 percent of poverty) and $1,225 per month for a couple (123 percent of poverty). The budget assumes savings of $127.6 million ($63.8 million General Fund) by eliminating 48,302 aged individuals and 20,538 disabled individuals from "no cost" Medi-Cal.

Many of these individuals could still obtain coverage under Medi-Cal but they all would need to pay a share-of-cost each month to receive services. This share-of-cost payment would of course be significant for people on fixed, low-incomes. (The share-of-cost is the amount by which that individual's income or assets exceeds the applicable Medi-Cal limits.)

8. Establish Standards for County Eligibility Determinations of Medi-Cal. The Administration proposes enactment of legislation which would establish standards for counties to meet regarding Medi-Cal eligibility determinations and redeterminations, and assumes that because of these new standards 563,135 Medi-Cal recipients, or almost 9 percent of the eligibles, will be terminated from enrollment for savings of $388 million ($194 million General Fund) in local assistance. The proposal also requests an increase of $896,000 ($448,000 General Fund) for state support to fund 9 positions to oversee the counties activities and to measure their performance.

Draft trailer bill legislation obtained from the Administration would establish county performance standards in several areas, including (1) completing eligibility determinations for several types of applications, including disability determinations, (2) processing newborn referral requests, and (3) conducting Medi-Cal redeterminations. All of these processes would need to be completed within specified timeframes as noted in the legislation or a county may, at the department's discretion, have their Medi-Cal county administration allocation reduced by two percent in the following year.

In order to facilitate the counties meeting these proposed performance standards, the budget provides an increase of $97.2 million ($48.6 million General Fund) over two years, including $54.9 million for 2002-03 and $42.3 million for 2003-04. The Administration contends that this adjustment would provide "full funding" for the counties to meet this potential obligation. However, it should be noted that even with this increased funding level, "full funding" would not be achieved due to reductions of over $450 million (total funds) taken from county Medi-Cal administration in prior years.

Further discussions will need to occur in order to recast the proposal to make it more equitable to fully address Medi-Cal enrollment standards, not just disenrollment, and to appropriately fund county administration..

9. Quality Assurance Fee of 6.5 Percent for Intermediate Care Facilities--Developmentally Disabled (ICF-DD). As part of the Mid-Year Reduction package, the Administration proposes to enact legislation effective April 1, 2003 which requires ICF-DD facilities and state Developmental Centers to pay the state an assessment of 6.5 percent on the total rate per patient day. This assessment would then be

used by the state to draw down matching federal funds. A portion of these new federal funds would be used to offset General Fund expenditures and to provide for a rate increase to ICF-DD facilities.

The Legislature postponed enactment pending resolution of the Governor's proposed 15 percent Medi-Cal rate reduction (which includes ICF-DD facilities) and its impact on this proposal, as well as a need to clarify how Developmental Center rates would be affected. Federal law requires ICF-DD facilities and Developmental Centers to be treated the same when it pertains to tax assessments on provider categories.

The Administration assumes total increased revenues of $5 million in the current year and $20 million annually. Of these new revenues, 75 percent would be provided back to these ICF-DD facilities as a provider rate increase. (In essence, this rate increase amounts to a pay back of the assessment fee plus half of the federal fund amount.) The remaining 25 percent of these funds would be used to offset $2.5 million (General Fund) for 2002-03 and $10 million (General Fund) for 2003-04.

It should be noted that the Administrations savings estimate will need to be modified. This is particularly true with respect to the Developmental Centers (DCs) where no fiscal assumptions have yet been developed. According to the Administration, a number of issues need to be resolved before an accurate estimate can be provided for the DCs. For example, the DCs also serve some individuals who are not eligible for Medi-Cal—such as forensic residents. The tax could not be applied to these individuals.

In addition to the need for statutory change, the state would need to submit a Medicaid State Plan amendment to the federal CMS for approval. It should be noted that several other states have implemented similar programs for their ICF-DD populations.

This is an excellent idea for the ICF-DD facilities for it enables the state to obtain additional federal funds and to use a portion of those funds to enhance the quality of care for individuals with developmental disabilities. It should be noted that ICF-DD facilities are almost 100 percent reliant on Medi-Cal funding and could equally benefit from the rate adjustment.

Primary Care, Family Health, Public Health & Environmental Health

Summary of Decreases and Fund Shifts

- Transfers fiscal responsibility of $143.3 million (savings of $66.6 million General Fund, and a fund shift of $18.7 million in federal funds and $58 million in Proposition 99 Funds) in family health and public health programs, along with a new revenue stream, to the counties as part of the "Healthy Communities" Realignment proposal. (This is discussed further, below.)

- Proposes to suspend for one year the $20.2 million (General Fund) appropriation for the County Medical Services Program (CMSP). This $20.2 million has been suspended for the past several years since the CMSP has had reserve funds available. However, it is unknown at this point how the Governor's Realignment proposal may eventually affect this program since he is proposing to transfer all county health services back to the counties.

- Reduces by $10 million (Tobacco Settlement Fund) in 2002-03 and $15 million (General Fund) in 2003-04 the Prostate Cancer Treatment Program due to lack of utilization. The proposed budget year reduction would leave $5 million available for the program. The Legislature did adopt the current year reduction.

- Proposes to eliminate funding for the Cancer Research Program for savings of $12.5 million (General Fund) in 2003-04. The Legislature did not adopt the current year reduction of $6.5 million (General Fund).

- Eliminates the Rural Demonstration Project funds of $3 million (General Fund) which was used for infrastructure development at rural hospitals, clinics and private physicians' offices, including the purchase of mobile health vans and medical/dental equipment, assistance to complete seismic retrofitting for rural hospitals, and the payment of salaries to address provider shortages in rural areas.

- Deletes $1.1 million (General Fund) for domestic violence prevention outreach which was intended to find underserved populations who are potentially in need of services but not using shelter programs. This proposed reduction represents 50 percent of the funding used for these outreach purposes. These underserved populations have historically included women of color and teens. Presently there are 15 contracts funded at $150,000 each. To implement the Administration's proposal, either each contract would need to be reduced by half (or a similar factor), the number of contracts would need to be reduced, or a combination of the two actions could be done. The Administration has not yet proposed an approach.

- Reduces by almost $1.3 million (General Fund) HIV education and prevention, including $1 million in funds historically allocated to the Department of Education, $150,000 used to assist local health departments in federally required evaluation of local intervention activities, $50,000 for a focus group study of risk behaviors for gay men and $34,000 for a contract with a correction facility to provide HIV-related training to clinical staff who work with inmates.

- Reduces by $1.7 million (General Fund) support for the Family Planning Outreach Information and Education Project which is designed to decrease teen and unintended pregnancy through prevention education.

- Eliminates the TeenSMART Outreach Program which provides prevention education information to adolescents for savings of $848,000 (General Fund).

- Eliminates the Teen Pregnancy Prevention Media Campaign which provides prevention education information to adolescents for savings of $7.8 million (General Fund).

- Eliminates the Botulism Immune Globulin (BIG) Program due to fund insolvency for savings of $2 million ($500,000 General Fund and $1.5 million special fund).

- Reduces by $2.8 million (General Fund) state support by reducing costs associated with DHS owned and operated facilities, reducing out-of-state travel, and eliminating the distribution of Calstars Reports.

- Proposes to eliminate the Gynecological Cancer Information Program for savings of $150,000 (General Fund) in 2003-04. The Legislature did not take this reduction as proposed in the Mid-Year Reduction package.

- Deletes funding for Valley Fever Vaccine Research for savings of $700,000 in 2003-04. The Legislature did adopt the Mid-Year Reduction proposal to reduce by $350,000 in the current year.

- Reduces state support by 47 positions and $3.3 million ($1.9 million General Fund, $600,000 federal funds and $800,000 special funds) to reflect the Administration's proposed realignment proposal.

- Eliminates the funds used to produce informational materials for the Newborn Hearing Screening Program for savings of $290,000 (General Fund).

Summary of Increases

- Provides $112.3 million (various special funds) to reflect funding made available from Proposition 50—Water, Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002—to facilitate

various statewide water security improvements and to provide safe drinking water grants and loans to local water agencies.

- Augments by $70.2 million (various special funds) (one-time only) to reflect available federal grants and a three-year extension of 10.5 positions in the Small Water System Technical Assistance Program.

- Continues to provide $20 million (federal funds) for the Community Challenge Grants Program which promotes community-based strategies to prevent teenage pregnancy and absentee fatherhood.

- Recommends an increase of $15.5 million (federal funds) in 2002-03 and $84.4 million (federal funds) in 2003-04 for the Women, Infants and Children Supplemental Nutrition (WIC) Program to reflect adjustments in the federal grant. The 2002-03 increase would serve an additional 24,000 participants and the 2003-04 increase would serve an additional 127,000 participants.

- Proposes a *net* increase of $2.3 million (total funds) for the AIDS Drug Assistance Program (ADAP). This net increase consists of the following components:

    - Reduction of $7.2 million (General Fund) to reflect implementation of proposed copayment legislation which would establish a three-tiered income-based system to require ADAP clients to assume a copayment obligation on a per prescription basis. Revenues from the copayment would be used to fund ADAP.
    - Increase of $8.3 million (General Fund) to make adjustments to the ADAP funding base.
    - Increase of $8 million (one-time only) in drug manufacturer rebates, which have recently been collected, to offset General Fund support.
    - Increase of $1.240 million in drug manufacturer rebates which will be on-going.

- Provides $4 million in General Fund support to backfill for $4 million in federal Maternal and Child Health block grant funds to continue funding of domestic violence shelters at their current year level. The $4 million in federal block grant funds was available on a one-time only basis last year.

- Appropriates an additional $1.7 million (federal grant funds) to support cervical cancer screening for women enrolled in both the Breast and Cervical Cancer Control Program and the Breast Cancer Early Detection Program.

- Requests $1.6 million ($864,000 General Fund) for equipment and ongoing information technology costs for the Richmond Laboratory Campus.

- Requests an increase of $405,000 ($234,000 General Fund) to fund five positions to develop, implement and operate a drug rebate program for the California Children's Services Program (CCS) and the Genetically Handicapped Persons Program (GHPP).

- Requests an increase of $316,000 ($205,000 General Fund) to fund three positions and a contract to contain rising costs in the Genetically Handicapped Persons Program (GHPP), including revising regulations regarding GHPP eligibility, checking for third-party payor responsibility, reviewing all requests for blood factor products that are over $25,000, and conducting outreach and education activities on the proper use of the program.

- Increases by $1.3 million (Radiation Control Fund) to implement the provisions of SB 2065 (Kuehl), Statutes of 2002, regarding developing an inventory for low-level radioactive waste generators, including developing and implementing regulations, creating a comprehensive data base system, and preparing summary reports. The funds will be used to hire six positions and to enter into two contracts in order to complete the work.

- Provides an increase of $360,000 (Radiation Control Fund) to meet requirements enacted by AB 2214, Statutes of 2002 regarding low-level radioactive waste disposal, including (1) developing regulations and site suitability standards for a disposal facility, (2) conducting industry outreach activities to encourage interest in submitting applications, and (3) encouraging waste reduction practices by users.
- Increases by $750,000 (Health Statistics Fund) to contract out functions relating to implementation of SB 247, Statutes of 2002, including to develop and implement a single statewide database of imaged birth and death records and to be able to electronically redact signatures from these certificates.
- Establishes a special fund—Lupus Foundation of American—in order to disburse up to $250,000 (Tax Check Off funds) for activities related to the prevention, treatment and research of Lupus.
- Provides an increase of $488,000 (Food Safety Fund) to continue the Food Safety Industry Education and Training Program.
- Provides $125,000 (Reimbursements) to fund two limited-term positions to carry out the School Health Connections Program and policy-related activities.

Issues for Primary Care, Family Health, Public Health and Environmental Health

1. "Healthy Communities" Realignment—Public Health Components. The Administration proposes to realign several programs in the overall public health area for a total fund shift of $143.3 million (savings of $66.6 million General Fund, and a fund shift of $18.7 million in federal funds and $58 million in Proposition 99 Funds). This includes the following programs and their expenditures (total funds):

• Expanded Access to Primary Care(EAPC)	$30.3 million (total funds)
• Indian Health Program	$6.5 million (General Fund)
• Rural Health Clinic & Clinic Grants in Aid	$ 8.8 million (General Fund)
• Seasonal Agricultural & Migrant Workers Program	$ 6.9 million (General Fund)
• Adolescent Family Life Program	$22.2 million (total funds)
• Black Infant Health Program	$ 8 million (total funds)
• Local Health Department –Maternal & Child Health	$ 7.4 million (total funds)
• County Health Services Public Health Subvention	$ 2 million (total funds)
• California Healthcare for Indigent Persons Program	$46 million (Proposition 99)
• Rural Health Services	$ 4.3 million (Proposition 99)
• Managed Care Counties	$926,000 (Proposition 99)

A. Clinic Programs: The community clinic programs, including EAPC, Indian Health, Rural Health Clinic, Seasonal Agricultural & Migrant Workers and Clinic Grants in Aid, are programs that provide funds to non-profit community-based clinics. Generally, each of these programs operates through an application process whereby the DHS, using extensive clinic data, awards funding based upon patient levels of service, uncompensated care, level of historically under served populations and related factors. Three of the programs—American Indian Health, Rural Health Clinics and Seasonal Agricultural & Migrant Workers—are designed to provide assistance for underserved, often medically needy populations.

These programs were never designed to be county-operated for several reasons. First, community-based clinics provide services to very low-income, uninsured individuals, including children, who have medical

needs. These services are not county specific nor neatly bound by a geographic county line, for medical services are often regionally-focused and provided based on medical need and demand.

Second, community-clinics are significant providers of health care to the uninsured in most counties, yet often receive a minor share of the county health care budget for their care. Therefore shifting funding may enable some counties to withdraw some portion of their own funds from this responsibility which would result in further erosion of safety net funding.

Third, the programs allocate funds based upon data-driven needs. This requires the clinics who receive funding to analytically present their funding need. If these funds are transferred to the counties, the programs may end up being purely formula-driven and therefore, not responsive to changing demographics and medical service area needs.

B. Maternal & Child Health Programs—AFLP and Black Infant Health. The Adolescent Family Life Program (AFLP) and Black Infant Health Program are two highly successful, highly evaluated programs which have been in existence for numerous years. Both programs utilize non-profit, community-based providers for services. Neither of these programs operate statewide. Both serve selected, targeted geographic areas due to funding limitations and need.

The AFLP provides counseling, education and support services for pregnant and parenting teens, including fathers, and their infants. The Black Infant Health Program conducts targeted, coordinated activities to address underlying causes of infant mortality, low birth weight and other poor reproductive health outcomes of high-risk African American women. The program also supports the development of projects that evaluate and refine effective models of practice in the areas of health behavior modification, prenatal care outreach, prevention, and the role of men in parenting. It is one of the few state programs that directly addresses health disparities within the African American population.

Both of these programs are operating well, have outcome measurements, utilize community-based experts and are not geographic-specific to counties. Further, the federal Title V Maternal and Child Health block grant funds require these programs to provide data and meet certain other federal requirements. These types of programs are more effectively operated with the state serving as the overall fiscal agent, not counties.

C. California Healthcare for Indigent Persons (CHIP) Program and Rural Health Services (RHS). A key purpose of Proposition 99 funds was to fund medical services on behalf of those who are unable to pay. In addition, as directed by the Proposition itself, the funds must be used to supplement and not supplant existing funding. As such, the CHIP and RHS were initiated in 1989 as a legislative result of the passage of Proposition 99. These two programs are intended to assist providers in funding their uncompensated care costs for providing needed health care services to indigent individuals.

Existing state statute distributes Proposition 99 funds to the CHIP and RHS programs based on a formula which allocates moneys for hospitals, physicians and other types of providers for uncompensated indigent health care services. These funds are provider specific, not county specific.

In addition, funding for both programs, particularly CHIP has significantly deteriorated over the past two years. For example, the Budget Act of 2002 appropriated a total of $89.7 million for CHIP whereas $46 million is proposed for 2003-04 for a reduction of over 52 percent.

The funding for these two programs is small, not relevant to county boundaries and would require some modicum of additional monitoring (to determine supplementing versus supplanting) if passed to the counties. It does not make good policy sense.

2. Proposition 99-Funded Programs. Expenditures of $314.6 million (Proposition 99-Funded Accounts) are proposed in 2003-04 for health-related programs, including funds allocated to the DHS,

MRMIB, UC research, and OSHPD. Of the total amount, $135.4 million is allocated for programs administered by the DHS.

Overall, total revenues for Proposition 99 continue to rapidly decline. This decline was escalated due to increases in the tobacco product surtax that were adopted through Proposition 10. Proposition 10 holds harmless the Health Education Account and the Research Account of Proposition 99, but does not provide a backfill for the other health care accounts.

The budget year reflects a reduction of $33 million in revenues from the revised current year. This reduction, coupled with higher expenditures for the Access for Infants and Mothers (AIM) Program has resulted in the Administration proposing adjustments to several of the DHS programs.

The DHS funding level reflects the following key proposals:

- Shifts funding for the California Healthcare for Indigent Persons Program ($46 million), Managed Care County Allocation (926,000), Rural Health Services Program ($4.3 million) and Expanded Access to Primary Care (EAPC) Program ($6.8 million) to the counties, along with a total of $58 million (Proposition 99 Funds), as part of the Governor's Realignment proposal entitled "Healthy Communities".
- Eliminates funding for the Comprehensive Perinatal Outreach Program for a reduction of $1.3 million.
- Reduces the Anti-Tobacco Media Campaign by $4.4 million leaving an appropriation of $16.7 million for this purpose.
- Reduces the Local Lead Agencies by $1.5 million leaving an appropriation of $15 million for this purpose.
- Reduces the Breast Cancer Early Detection Program by $1.7 million (Proposition 99 Funds) to reflect a corresponding increase in federal grant funds. As such, the program will remain at its present funding level of $33.3 million.
- Decreases by $2.3 million (Proposition 99 Funds) DHS administration to primarily reflect the shift of certain programs to the counties as contained in the Governor's Realignment proposal—Healthy Communities.

3. AIDS Drug Assistance Program. ADAP is a subsidy program for low and moderate income persons with HIV/AIDS who have no health care coverage for prescription drugs and are not eligible for the Medi-Cal Program.. Under the program, individuals receive drug therapies through participating local pharmacies under subcontract with a statewide contractor. The state provides reimbursement for drug therapies listed on the ADAP formulary (about 146 drugs currently).

The budget proposes a *net* increase of $2.3 million (total funds) for the AIDS Drug Assistance Program (ADAP). This net increase consists of the following proposed components:

- Reduction of $7.2 million (General Fund) to reflect implementation of proposed copay legislation.
- Increase of $8.3 million (General Fund) to make adjustments to the ADAP funding base.
- Increase of $8 million (one-time only) in drug manufacturer rebates, which have recently been collected, to offset General Fund support.
- Increase of $1.240 million in drug manufacturer rebates which will be on-going.

The Administration's copay proposal would establish a three-tiered income-based system to require ADAP clients to assume a copay obligation on a per prescription basis ($30, $45 or $50 per script). ADAP clients with incomes of 200 percent of poverty or less would be exempt from the copay requirements. Based on the information provided by the DHS, about 6,000 ADAP clients, or 24 percent of the total clients, would be affected by the proposed copay.

The table below outlines how the DHS derived its estimate of savings.

Poverty Level	Estimated Clients	Percent Of Clients	Estimated Scripts	Copay Per Script	TOTAL Estimated Copay
100% or less	10,851	43.41%	338,607	$0	$0
101% - 200%	8,151	32.60%	255,284	$0	$0
201% - 300%	3,708	14.83%	126,926	$30	**$3,807,790**
301% - 400%	1,930	7.72%	68,106	$45	**$3,064,768**
400% or more	269	1.08%	8,862	$50	**$443,077**
Unknown	90	0.36%	929	$0	N/A
TOTAL	**25,000**	**100.00%**	**798,713**		**$7,315,636 Maximum Level**

According to the DHS information an average individual between 200 and 300 percent of poverty could be expected to pay about $1,026 annually for their prescriptions ($30 per). Using the sliding fee scale, an average individual between 300 and 400 percent of poverty would pay about $1,588 annually. Given this level of expenditure, the Legislature may want to consider adjustments to the copay proposal, as well as consider additional options, such as reviewing the level of drug manufacturer rebates and whether additional program efficiencies could be obtained.

4. California Children's Services (CCS) Program. CCS depends on a network of specialty physicians, therapists and hospitals to provide medical care to financially eligible, enrolled children. It is the oldest managed care program in the state and the only one focused specifically on children with special health care needs.

Total program expenditures of $141.4 million ($69.5 million General Fund, $61.5 million County Realignment Funds, $4.7 million federal Maternal & Child Health block grant funds, $2.6 million drug rebates, $260,000 patient fees, and $2.8 million other funds) are proposed for 2003-04. Key changes proposed for CCS include the following:

- Decrease of $3 million (General Fund) to reflect a 15 percent provider rate reduction effective July 1, 2003.
- Assumes implementation of drug rebates for blood factor product for savings of $5.2 million ($2.6 million General Fund) effective July 1, 2003.

Through the Budget Act of 2000, the CCS Program was provided a rate increase of 39 percent. Other than a five percent increase granted in 1999, no rate adjustment had been provided since 1982. These rate adjustments resulted from data obtained from the Senate Office of Research and their comprehensive

report on the program (published in 2000), plus rate analyses conducted by the DHS, as well as the American Academy of Pediatrics and specialty physician groups.

To reduce these rates would conceivably result in significant problems that were experienced previously. For example, it was documented that (1) many provider groups were having extreme difficulty retaining and hiring for pediatric subspecialty positions, (2) patients were experiencing tremendous waiting times to receive necessary subspecialty services (three months to a year depending on the service), and (3) patients in rural and suburban areas were having to travel long distances to find a doctor authorized by CCS.

In lieu of the proposed rate adjustment, the Legislature may want to consider other cost saving options, such as using utilization controls on certain pharmaceuticals, medical supplies and laboratory services or other related program efficiencies.

5. Genetically Handicapped Persons Program (GHPP). The GHPP provides diagnostic evaluations, treatment services and medical case management services for adults with certain genetic diseases, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, and certain neurological metabolic diseases.

Expenditures for the GHPP have been rapidly increasing over several years as noted in the chart below. In fact, the program increased well over 320 percent from 1996 to 2001 (the last year that actual expenditures are available). Of the $36 million proposed for expenditure in 2003-04, the DHS estimates that about $29.9 million, or 83 percent, is needed for program participants with Hemophilia.

Fiscal Year	Actual General Fund Expenditures
1996-97	$12 million
1997-98	$16.5 million
1998-99	$23.8 million
1999-2000	$34.9 million
2000-01	$31.2 million
2001-02	$38.8 million
2002-03	$32 million (plus $6.6 million in drug rebates) (Estimated)
2003-04	$28.5 million (plus $7.6 million in drug rebates) (Proposed)

Through the Budget Act of 2002, authority was provided to the DHS to negotiate drug rebates for blood factor products. Blood factor products are used extensively in the program, primarily to treat Hemophilia, and are very expensive. These products are clinically complex and are usually made through the purification of plasma proteins or a process of genetic engineering. Prescriptions are usually written as brand name products and cannot be considered interchangeable.

The budget proposes expenditures of $36 million ($28.5 million General Fund) for the GHPP to fund an average total caseload of 1,881 individuals. This reflects an average cost of about $19,138 per program participant. In order to curtail expenditures, the Administration proposes the following adjustments:

- A 15 percent rate reduction, effective July 1, 2003, for savings of $4.2 million (General Fund);
- An increase of $1 million, for a total of $7.4 million, in drug rebates by contracting with all major blood factor manufacturers;
- Establishment of several cost contain measures, including implementation of utilization controls on blood factor products, assuring that other health care coverage is utilized prior to accessing the GHPP and implementing a more efficient system for the assessment and collection of client participation fees for a total savings of $1 million (General Fund).

The Legislature may also want to work with the Hemophilia Centers to seek other cooperative solutions that may be feasible without jeopardizing the health of program participants.

4280 Managed Risk Medical Insurance Board

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health coverage through private health plans to certain groups without health insurance. The MRMIB administers the (1) Healthy Families Program, (2) Major Risk Medical Insurance Program, and (3) Access for Infants and Mothers (AIM).

The budget proposes total expenditures of $972.4 million ($92.3 million General Fund, $511.6 million Federal Trust Fund, $220 million Tobacco Settlement Fund, and $148.5 million in other funds) for all programs administered by the Managed Risk Medical Insurance Board. Of this amount, $7.1 million is for state operations and $965.3 million is for local assistance.

The budget proposes key changes to the Healthy Families Program and the Access for Infants and Mothers Program. These are discussed in more detail below.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Program Source				
Major Risk Medical Insurance (including state support)	$41,220	$40,082	($1,138)	(2.8)
Access for Infants & Mother (including state support)	$96,461	$117,488	$21,027	21.8
Healthy Families Program (including state support)	$706,673	$814,780	$108,107	15.3
Totals, Program Source	$844,354	$972,350	$127,996	15.2
General Fund	$31,285	$92,310	$61,025	195
Federal Funds	$445,867	$511,585	$65,718	14.7
Tobacco Settlement Fund	$234,752	$220,000	($14,752)	(6.3)
Other Funds	$132,450	$148,455	$16,005	12
Total Funds	$844,354	$972,350	$127,996	15.2

The Healthy Families Program

Summary of Funding.

The Healthy Families Program provides health, dental and vision coverage through managed care arrangements to children in families with incomes up to 250 percent of the federal poverty level. Families pay a monthly premium and copayments as applicable. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

A total of $814.8 million ($85.3 million General Fund, $220 million Tobacco Settlement Fund and $498.5 million Federal Title XXI Funds, and $11 million Reimbursements) is proposed for the Healthy Families Program, including state administration. Of this amount, $809.7 million ($83.6 million General Fund, $220 million Tobacco Settlement Fund, $495.2 million Federal Title XXI Funds and $10.9 million Reimbursements) is for local assistance.

The budget assumes a total enrollment of 768,232 children as of June 30, 2004, for an increase of 99,715 children over the revised current year enrollment level. This enrollment figure is based on the sum of four population segments as follows:

- Children in families up to 200 percent of poverty: 556,755 children
- Children in families between 201 to 250 percent of poverty: 148,789 children
- Children in families who are legal immigrants: 25,573 children
- Child Health Disability Prevention (CHDP) Gateway Access: 37,115 children

The Administration assumes that net enrollment growth in the budget year will begin to slow as total enrollment reaches the end of the universe of potential eligible children and disenrollments and new enrollments equal out.

Summary of Key Adjustments.

- Assumes deferral of the parental coverage expansion until July 1, 2006. The Legislature had proposed to implement the parental coverage expansion as of October 1, 2002 but funding for this was vetoed by the Governor in the Budget Act of 2002.
- Eliminates the Rural Health Demonstration Projects for savings of $4.6 million ($1.7 million General Fund).
- Provides an increase of $108.3 million (increase of $54.3 million General Fund, $61.4 million Federal Title XXI Funds and $3 million in Reimbursements and a decrease of $10.4 million in Tobacco Settlement Funds) for increased enrollment of 99,715 children and related expenses.
- Deletes all funding for Healthy Families Outreach, certified application assistance training and payments. (This is discussed under the Department of Health Services item.)

Issues for the Healthy Families Program

Proposed Elimination of the Rural Health Demonstration Projects. The budget proposes to eliminate the Rural Health Demonstration Project funds used in the Healthy Families Program for savings of $4.6 million ($1.7 million General Fund and $2.9 million federal Title XXI funds).

The Rural Health Demonstration Projects are an integral component of the Healthy Families Program. They have been used to develop and enhance existing health care delivery networks for special populations and to address geographic access barriers. Specifically, the funds have been used to extend community clinic hours, expand telemedicine applications, provide bilingual specialty health care services, provide mobile medical services and dental services, and rate enhancements to increase HFP

provider networks in remote areas. According the Rural Demonstration Project 2002 Fact Book, over 238 projects have been funded with very successful and measurable, results.

The Legislature should consider options to continue the funding of these valuable projects.

Access for Infants and Mothers Program

Summary of Funding

The Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level (including the application of Medi-Cal income deductions). Eligible women select coverage from one of the nine participating health plans. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage.

A total of $117.5 million ($97.3 million Perinatal Insurance Fund, $7.1 million General Fund, and $13.1 million in Title XXI federal funds), including state support is proposed for AIM. Of this amount, $116.5 million is for local assistance. A total of 9,531 women and 138,237 infants are expected to enroll in AIM in 2003-04.

Currently, AIM offers coverage through 9 contracted health plans.

Summary of Key Adjustments.

- Increases by $20.9 million over the revised 2002-03 budget to provide coverage to an additional 1,245 women and 23,970 infants.
- Assumes savings of $977,000 (Proposition 99 Funds) by consolidating AIM infants into the Healthy Families Program.

Issues for the Access for Infants and Mothers Program

1. Consolidation of AIM. Over the past several years, costs and enrollment for AIM have exceeded budgeted levels. As a result, the MRMIB has submitted several requests to the Legislature for additional funds in order to avoid having to cap enrollment levels. At the same time, the primary funding source for AIM (Proposition 99 Funds) has continued to decline.

The MRMIB also notes that a separate program, such as AIM, with specialized services for cost-intensive enrollees makes it difficult to negotiate rates with health plans because the risk cannot be spread across a large purchasing pool (i.e., these are pregnant women only, no other enrollees). This in turn, limits the number of health plans willing to participate in the program.

As such, the Administration has proposed to consolidate AIM and enroll eligible infants into the Healthy Families Program at birth while continuing to provide women with prenatal and postpartum care through AIM. The MRMIB states that by merging AIM in this manner, the state should be able to obtain lower health plan rates for infants via the Healthy Families Program (larger risk pool), as well as achieve other economies of scale through consolidating certain program administration.

The Administration assumes savings of $977,000 (Proposition 99 Funds) in 2003-04 for this consolidation (January 1, 2004 effective date), with net annual savings of $10.2 million (total funds).

Specifically, infants in families between 200 and 250 percent of poverty would be funded through the Healthy Families Program using General Fund and federal Title XXI funds (35 percent/65 percent). AIM infants in families between 250 and 300 percent of poverty (above the Healthy Families Program income threshold) would be funded with 100 percent state funds (General Fund and Proposition 99 Funds).

It should be noted that this proposal will potentially affect expenditures in the California Children's Services (CCS) Program. This is because children enrolled in the Healthy Families Program are also eligible for CCS services if they meet the medical eligibility criteria. Therefore, MRMIB can potentially obtain better AIM rates because the risk of having high cost, medically involved infants is shifted to the CCS Program where the state and county pick-up the costs. The potential cost shift to the CCS Program is unknown at this time.

2. AIM Outreach Funding. The budget proposes to appropriate $2 million (Proposition 99 Funds) to conduct a wide variety of outreach activities, including (1) presentations and trainings for insurance agents, healthcare plans, schools and government agencies, (2) developing and distributing advertisements for television and print media, and (3) organizing media events.

This funding proposal is inconsistent with the Administration's approach in other health care programs where outreach, education, and information assistance has been stripped from the budget. For example, all of the outreach funding for Medi-Cal for children and Healthy Families has been deleted, funding for education activities in TeenSMART has been deleted, information regarding the Newborn Hearing Screening Program has been deleted and there are many other examples.

AIM has been over its estimated caseload every budget year since 1998. As such, outreach funding could be deleted during a time of fiscal crisis and used to support other health care service programs funded by Proposition 99 funds.

4300 Department of Developmental Services

The Department of Developmental Services (DDS) administers services in the community through 21 Regional Centers and in state Developmental Centers for persons with developmental disabilities according to the provisions of the Lanterman Developmental Disabilities Services Act. To be eligible for services, the disability must begin before the consumer's 18th birthday, be expected to continue indefinitely, present a significant disability and be attributable to certain medical conditions, such as mental retardation, autism, and cerebral palsy.

The purpose of the department is to (1) ensure that individuals receive needed services; (2) ensure the optimal health, safety, and well-being of individuals served in the developmental disabilities system; (3) ensure that services provided by vendors, Regional Centers and the Developmental Centers are of high quality; (4) ensure the availability of a comprehensive array of appropriate services and supports to meet the needs of consumers and their families; (5) reduce the incidence and severity of developmental disabilities through the provision of appropriate prevention and early intervention service; and (6) ensure the services and supports are cost-effective for the state.

Summary of Funding

The budget proposes total expenditures of $3.227 billion ($1.957 billion General Fund), for a *net* increase of $281.6 million ($130.9 million General Fund) over the revised 2002-03 budget, to provide services and supports to individuals with developmental disabilities living in the community or in state Developmental Centers.

Of the total amount, $2.537 billion is for services provided in the community, $655.1 million is for support of the state Developmental Centers, $35.4 million is for state headquarters administration and $4,951 is for state-mandated local programs.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Program Source				
Community Services Program	$2,259,667	$2,536,710	$277,043	12.3
Developmental Centers	$655,560	$655,132	-428	--
State Administration	$30,438	$35,389	4,951	16.3
State Mandated Local Program	$4	$4		
Total, Program Source	$2,945,669	$3,227,235	$281,566	9.6
Funding Source				
General Fund	1,826,777	1,957,632	130,855	7.2
Federal Funds	49,589	51,695	2,106	4.2
Program Development Fund	2,059	1,931	-128	-6.2
Lottery Education Fund	2,057	2,057		
Reimbursements: including Medicaid Waiver, Title XX federal block grant and Targeted Case Management	1,065,187	1,213,920	148,733	14
Total	$2,945,669	$3,227,235	$281,566	9.6

Community-Based Services Highlights

Summary of Funding for Community-Based Services Provided through Regional Centers.

The DDS contracts with 21 not-for-profit Regional Centers (RCs) which have designated catchment areas for service coverage throughout the state. The RCs are responsible for providing a series of services, including case management, intake and assessment, community resource development, and individual program planning assistance for consumers. RCs also purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities.

The budget proposes expenditures of $2.537 billion ($1.574 billion General Fund) for community-based services, provided via the RCs, to serve a total of 193,100 consumers living in the community. This reflects an increase of $277 million ($126.7 million General Fund), or 12.3 percent, over the revised 2002-2003 budget.

The funding level includes $432.2 million for RC operations and over $2.1 billion for local assistance, including funds for the purchase of services for consumers, program development assistance, the Early Start Program, and habilitation services. About 193,100 consumers are anticipated to be service through the Regional Centers. This reflects an increase of 9,560 consumers, or 5.2 percent over the current-year.

It should be noted that in reviewing the past five years of actual fiscal data (1996 to 2001), the budget for total program expenditures (including Regional Center operations and purchase of services) has increased by over 107 percent from $996.9 million (total funds) in 1996 to almost $2.1 billion (total funds) in 2001.

Summary of Key Reductions

- Reduces by $100 million (General Fund) the Purchase of Services category by assuming the adoption of legislation as of April 1, 2003 to implement "statewide purchase of services standards".
- Decreases by $101 million in General Fund support to reflect a commensurate backfill in reimbursements obtained from the Department of Health Services for increased receipts in federal funding obtained from expanded activities primarily associated with the Home and Community Based Waiver.
- Reduces by $65.7 million in General Fund support due to a corresponding increase in federal Title XX Social Services Block Grant reimbursements obtained from the Department of Social Services.
- Assumes the receipt of $31.5 million in revenues obtained through the implementation of a parental copayment for families with children ages 3 to 17 years living at home that access Regional Center services and who are *not* eligible for Med-Cal.
- Assumes a reduction of $2.1 million (General Fund) through implementing a change in eligibility to conform the definition of substantial disability to the federal standard. The federal standard requires the clinical determination of significant limitations in three or more of the seven major life activities.
- Continues the suspension of using Purchase of Service funds for the start-up of any new non-Community Placement Plan programs as enacted in AB 442, Statutes of 2002, the trailer legislation for the Budget Act of 2002.
- Continues the deferral of the intake and assessment process from 60 days to 120 days as enacted in AB 442, Statutes of 2002, the trailer legislation for the Budget Act of 2002.

Summary of Key Augmentations

- Increases by $114.8 million (General Fund) to recognize the transfer of the Habilitation Program from the Department of Rehabilitation to the DDS.
- Augments by $204.7 million (General Fund) to fund additional costs at the Regional Centers attributable to higher utilization of Purchase of Services by consumers and to reflect projected caseload growth of 10,870 consumers.
- Provides $790,000 to continue to pass through the federal portion of the SSI/SSP increase to Community Care Facilities (CCFs), effective January 1, 2004. About 20,800 people with developmental disabilities reside in 4,500 CCFs licensed by the Department of Social Services. As such, over 50 percent of consumers living in out-of-home placement settings reside in CCFs. Since the Budget Act of 1998, annual SSI/SSP increases have been passed through to CCF providers.
- Augments by $1.8 million (General Fund) DDS headquarters support to fund 24 new positions to implement a parental copayment assessment program.
- Provides $159,000 ($139,000 General Fund) for DDS to seek a Home and Community-Based Services Independence Plus Waiver to continue and expand the Self-Determination Projects.

Issues for Community-Based Services

1. Current-Year Deficiency Concerns. The revised 2002-03 budget as proposed in January reflects a deficiency of $40 million ($13.7 million General Fund, and $26.3 million Reimbursements) for the Regional Centers. This *initial* deficiency reflects preliminary data only. Consequently, this deficiency request will need to be updated in the May Revision when additional department data is available. Of this initial estimate, almost $30 million is attributable to increased utilization of services by

consumers. As such, it is likely that the base-line budget for 2003-04 will also need to be increased at the May Revision, absent any other corrective adjustments.

2. Implement Statewide Standards for the Purchase of Services. A decrease of $100 million (General Fund) is assumed through enactment of statewide purchase of services standards. The Administration is seeking approval of legislation in the Special Session in order to achieve full-year savings in the budget year. Though the proposed language is referred to as establishing "statewide standards" for the purchase of services, the language does not function in this manner. It simply provides the DDS with broad reduction authority.

For example, the language does *not* articulate any principles, process, or framework that would address what the standards would be nor how they would be applied on a statewide basis. Instead, the proposed language grants very broad authority to the DDS to: (1) prohibit any consumer services or supports by type (such as Respite), (2) limit the type, duration, scope, location, amount, or intensity of *any* services and supports provided to consumers through the purchase of services by the Regional Centers, and (3) impose payment reductions and closure days on categories of vendors in order to insure that Regional Centers stay within their budgeted appropriation level.

In addition, the language explicitly states that consumers may *not* appeal a change in their services or supports if (1) the type of service or support has been prohibited through the actions of the DDS, or (2) the individual service or support has been reduced at the direction of the DDS in order to ensure that Regional Centers stay within their budgeted appropriation level.

The language also expresses that it is not the Legislature's intent to endanger a consumer's health or safety, nor place a consumer in a more restrictive setting in violation of the Olmstead Decision (1999, 527 U.S. 581). However, it is unclear how the DDS and RCs are to monitor this in order to assure something inappropriate does not occur.

The Administration has not provided any fiscal detail as to how the savings are to be achieved, because none exists. The savings figure simply assumes that the $52 million (General Fund) unallocated reduction taken in the Budget Act of 2002 is subsumed in the proposed statewide standards and that additional funds are obtained to achieve the round savings figure of $100 million (General Fund).

In reviewing the 2000-01 actual expenditures for the Regional Center purchase of services line item, it is evident that $100 million in General Fund savings would be near impossible to achieve unless certain services are eliminated and provider rates in other service categories are reduced. This is because certain service categories—such as residential services and supported living—would be extremely difficult to reduce since these are fundamental services whose costs reflect staffing standard requirements, housing needs and basic amenities. These two service categories constitute 30 percent of expenditures for the purchase of services.

Other service categories such as Behavioral Services, Medical Care and Services, Medical Equipment and Supplies, and Therapy Services may be difficult to reduce for a reduction might endanger the health, safety and life of an individual. In addition, expenditures for these services are relatively small.

The other significant service categories include Adult Day Programs (22 percent of expenditures), Respite Services (7 percent), Transportation Services (7 percent), and Infant Development Services (4 percent). After the Residential Services category, these services reflect the highest expenditures. Finally, there are some very small categories, such as Social Recreational Activities and Camp Services; however, these expenditures are relatively minor so their elimination would not amount to much savings.

Given the nature of the above outlined expenditures, it is likely that a significant level of the Administration's proposed reduction would need to come from Adult Day Programs, Respite, Transportation and some more minor cost areas such as Social Recreational Activities.

If purchase of service reductions are to be enacted, it is recommended to completely re-craft the language to establish a more comprehensive framework for service determinations, including stakeholder community participation, and to establish a more reasonable savings level that recognizes the need to not reduce certain core services.

3. Enhanced Federal Funds and the Home and Community-Based Waiver. Over the course of the past two years, the state has been aggressively pursing additional federal funds, most notably under the Home and Community-Based Waiver. Under this Waiver, California can offer "nonmedical" services to individuals with developmental disabilities living in community settings who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility, or related conditions. Use of these "waiver services", such as assistance with daily living skills and day program habilitation, enable people to live in less restrictive environments such as in their home.

The Waiver has allowed the state to conserve General Fund dollars by shifting Medicaid (Medi-Cal) eligible beneficiaries to Waiver services while granting flexibility and assisting the state in complying with the Coffelt Settlement and the Olmstead Decision.

The budget proposes to capture an increase of almost $101.5 million in additional federal funds obtained through a series of program changes. Of this amount, (1) $92.1 million will be used as a General Fund backfill in the Purchase of Services line-item, (2) $6.5 million is proposed for Regional Center Operations support, (3) $1.6 million is proposed for transportation providers to complete certain billing requirements, and (4) $1.3 million is proposed for certain Headquarters support functions.

The DDS proposes to obtain these increased federal revenues by conducting the following activities:

- Increasing the cap on the number of consumers the state can enroll in the Home and Community-Based Waiver from 46,447 to 55,000 consumers.
- Increasing the percentage of contracted services eligible for federal reimbursement under the Home and Community-Based Waiver.
- Adding and redefining selected services offered under the Home and Community-Based Waiver.
- Implementing a system to capture funding for the administrative costs incurred by the Regional Centers that pertain to Waiver functions.
- Recalculating and revising the method used for making rate determinations under the state's Targeted Case Management Program.
- Obtaining federal matching funds for some transportation services.

The above proposed activities are reasonable proposals in order to obtain enhanced federal funds. Most of these options will require federal approval through Medicaid (Medi-Cal) State Plan Amendments and in some cases, Waiver amendments. Further, some system modifications in the areas of vendor billing, Regional Center billing, and the like will need to be thought through and completed.

In addition to the above items, there is further potential to obtain more federal funding. For example, there is potential to restructure or add more services to the Waiver, particularly in the areas of respite care and education services. In addition, some administrative functions may qualify for a 75 percent federal match instead of the 50 percent match that is assumed in the proposal. Further research on this issue is forthcoming.

Also it should be noted that the state is not yet claiming reimbursement under the Home and Community-Based Waiver for the South Central Los Angeles Regional Center; however, discussions are ongoing to bring them under the Waiver. This alone could increase federal funding by an additional $5 million.

4. Proposed Implementation of a Parental Copayment Assessment Program for Services. The budget assumes increased revenues of $31.5 million through the implementation of a Parental Copayment Assessment Program to be enacted through trailer bill legislation. This program would require parental financial participation for children who live at home and receive services from Regional Centers. The key components of this copayment program are as follows:

- Copayments would be assessed on families with children ages 3 to 17 years living at home that access Regional Center services and who are *not* eligible for Med-Cal.
- Copayments would be assessed on families at or above 200 percent of the federal poverty level, based on annual adjusted *gross* income as provided by the Franchise Tax Board.
- Families would pay up to a maximum of 10 percent of their gross income for the cost of services provided through the Regional Center for the child. For example, a family making $50,000 annually would pay up to $5,000 (10 percent), not to exceed the costs of services purchased for the child. The entire copayment amount would have to be paid within one year of the initial assessment.

It should be noted that the Administration's proposal does not utilize a sliding-fee methodology. All applicable families with incomes 200 percent of poverty or above would be required to pay up to a maximum of 10 percent of their families' annual gross income.

The budget also requests an increase of about $1.8 million (General Fund) and 24 new positions for DDS headquarters to develop and implement the program.

5. Proposed Revision of Eligibility Definition. The budget proposes savings of $2.1 million (General Fund) through legislation which would apply the federal standard for "substantial disability" to existing state eligibility criteria. The federal standard requires the clinical determination of significant limitations in three or more of the seven major life activities. These major life activities would address clinical capacity in the areas of communication, learning, mobility, self-care, self-direction, economic self sufficiency, and independent living. The Administration states that the new standard would be applied prospectively so that those currently receiving services will not be affected.

Based on existing consumer characteristics, the DDS estimates that about 400 persons per year would *not* be eligible for Regional Center services. These estimated 400 persons would generally be school age children or young adults with mild mental retardation, or another disability, without severe medical or behavioral needs. The DDS further states that the clinical judgement of the Regional Centers in applying the proposed new standard for substantial disability would be the key determining factor.

State Developmental Center Highlights

Summary of Funding for the State Developmental Centers

The DDS operates five Developmental Centers (DCs)—Agnews, Fairview, Lanterman, Porterville and Sonoma. Porterville is unique in that it provides forensic services in a secure setting. In addition the department leases Sierra Vista, a 54-bed facility located in Yuba City, and Canyon Springs, a 63-bed facility located in Cathedral City. Both facilities provide services to individuals with severe behavioral challenges.

The budget proposes expenditures of $690.5 million ($368.5 million General Fund), including state support of $13.8 million, to serve 3,596 residents who reside in the state Developmental Center system. This reflects a caseload decrease of 71 residents and a marginal net decrease in funds of $428,000 as compared to the revised 2002-03 budget.

According to DDS data, the average cost per person residing at a DC is about $179,000 annually. Due to differences between the DCs, including resident medical and behavioral needs, overall resident population size, staffing requirements, fixed facility costs and related factors, the annual cost per resident varies considerably and is as follows:

- Canyon Springs $255,574 annual cost per resident
- Sierra Vista $213,923
- Agnews $208,935
- Lanterman $158,336
- Sonoma $157,530
- Fairview $147,690

Summary of Key Adjustments

- Reduces by $6.3 million ($3.7 million General Fund) and 91 Level-of-Care staff based on the revised DC population level.
- Reduces by $386,000 ($187,00 General Fund) and 8 Non-Level of Care staff based on the revised DC population level.
- Augments by $44.5 million (Public Building Construction Fund) for preliminary plans, working drawings and construction of a 96-bed expansion in the secured treatment area at Porterville Developmental Center.
- Augments by $5.7 million (Public Building Construction Fund) for preliminary plans, working drawings and construction of a recreation complex in the secured treatment area at Porterville Developmental Center.
- Provides an additional $406,000 ($237,000 General Fund) and five new state positions to complete investigations of consumer safety at the DCs in a timely manner.
- Increase of $20.2 million ($11.8 million General Fund) for employee compensation.
- Increase of $12.2 million ($7.1 million General Fund) for employer retirement contributions.
- Increase of $1.1 million for State Compensation Insurance Fund costs.

Issues for the Developmental Centers

Bay Area Project and Future Closure of Agnews. The Administration proposes to develop a strategic plan to among other things, develop community capacity and resources to facilitate the eventual transfer of individuals from Agnews DC to either an appropriate community setting or to another DC. The actual closure of Agnews would not occur until the end of June 2005, at the earliest.

This proposal would establish a project team to begin assessing available resources and identifying additional resources necessary to transition consumers. No additional funding is being requested for this purpose. All budget year expenditures would be absorbed within the Sacramento headquarters.

4440 Department of Mental Health

The Department of Mental Health (DMH) administers the Bronzan-McCorquodale and Lanterman-Petris-Short Acts providing delivery of mental health treatment services through **(1)** a state-county partnership and **(2)** the involuntary treatment of the mentally-disabled. The DMH is responsible for the operation of five state hospitals and the acute psychiatric units at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

The budget proposes expenditures of $2.319 billion ($786.8 million General Fund) for mental health services. This reflects a decrease of $60.2 million, or 7 percent, over the revised 2002-03 budget. Of the total amount, $1.588 billion is for local assistance, $693.1 million is for the state hospitals, $19.3 million is for department support, and $6 million (General Fund) is for state mandated local programs.

In addition, it is estimated that almost $1.174 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget. This amount does not include the estimated $14 million which may be made available from the Vehicle License Collection Account.

Further, an appropriation of $21.5 million ($736,000 General Fund and $20.8 million Public Building Construction Fund) is provided for capital outlay purposes.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Program Source				
Community Services Program	$1,577,648	$1,625,631	$47,983	3
Long Term Care Services	659,608	693,121	$33,513	5
State Mandated Local Programs	6	6		
Total, Program Source	$2,237,262	$2,318,758	$81,496	3.6
Funding Source				
General Fund	$846,960	$786,789	($60,171)	
Federal Funds	60,834	60,839	5	
Reimbursements	1,325,684	1,467,919	142,235	
Other Funds	3,784	3,211	(573)	
Total Department	$2,237,262	$2,318,758	$81,496	

Community-Based Mental Health Services Highlights

Summary of Funding for Community-Based Mental Health Services. The budget proposes expenditures of almost $1.588 billion ($224.3 million General Fund) for community-based local assistance, including the Conditional Release Program and state mandated local claims. This reflects an increase of $131.9 million (total funds) and a reduction of $95.9 million (General Fund) as compared to the revised 2002-03 budget.

In addition, it is estimated that $1.095 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget. This estimate is based on the following revenue estimates:

- Sales Tax $820,568,000
- Vehicle License Fee Account $265,784,000
- Vehicle License Fee Growth Account $8,718,000
- Sales Tax Growth Account $-0-

Realignment revenues deposited in the Mental Health Subaccount, as established by formula outlined in statute, are distributed to counties until each county receives funds equal to the previous year's total. Any realignment revenues above that amount are placed into a growth account. Generally, first claim on the distribution of growth funds are caseload-driven social services programs. Any remaining growth (i.e., "general" growth) in revenues is then distributed according to a formula in statute.

As discussed in a recently released report on mental health realignment (AB 328 Realignment Data, Department of Mental Health, February 5, 2003), due to continued caseload growth in Child Welfare services and Foster Care, as well as cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced.

Summary of Key Reductions and Fund Shifts

- Reduces by $46 million ($23 million General Fund) the state allocation provided to County Mental Health Plans for implementing Mental Health Manage Care.
- Shifts $74.9 million in expenditures for the Integrated Services to the Homeless Program and the Children's System of Care Program to the counties to reflect the Governor's "Mental Health" Realignment proposal. If a dedicated, reliable revenue source is provided for this purpose, this transfer of responsibility makes programmatic sense. Counties have done an excellent job at operating both programs effectively and efficiently, as noted through several independent evaluations of both programs.
- Decreases by $15 million (General Fund--Proposition 98) to reflect the elimination of the Early Mental Health Initiative Program.

Summary of Key Augmentations

- Increases by $230.4 million (Reimbursements from the DHS for Medi-Cal) to reflect adjustments for the continued expansion of the Early Periodic Screening Diagnosis and Treatment (EPSDT) and Therapeutic Behavioral Services (TBS). The Department of Finance states that the full effect of cost control measures implemented by the Legislature through AB 442, Statutes of 2002, trailer bill to the Budget Act of 2002, will not be realized until 2004-05. However, the proposed $230.4 million increase does assume a smaller growth rate.
- Continues to provide $1.2 million (General Fund) for supplemental funding for Community Treatment Facilities (CTFs). This level of funding provides a supplement of $2,500 per child per month. According to the DMH, five CTFs are currently in operation with two additional programs under development.
- Provides $6.2 million ($1.7 million General Fund) and one new state position (limited-term) to implement federally required External Quality Reviews of County Mental Health Plans to ensure that the department's Mental Health Managed Care Waiver is brought into compliance with new federal regulations governing the operation of Medicaid managed care programs.

- Increases by $4 million (federal reimbursements) for the Healthy Families Program to reflect a caseload adjustment.
- Augments by $345,000 (General Fund) and five new state positions to comply with AB 1454, (Thomson), Statutes of 2002, which requires the DMH to provide fingerprint images to the DOJ for a criminal background check on administrative and direct care staff of Psychiatric Health Facilities and Mental Health Rehabilitation Centers prior to their licensure or license renewal.

Issues for Community-Based Mental Health

Mental Health Managed Care. The state's Mental Health Managed Care Program operates under a federal waiver whereby County Mental Health Plans are responsible for the provision of public mental health services, including those for Medi-Cal recipients.

Under this model the County Mental Health Plans, through a system of contracts with the state, are at risk for the state matching funds for services provided to Medi-Cal recipients. An annual state General Fund allocation is provided to County Mental Health Plans for this purpose, though counties also use a substantial amount of county realignment funds—Mental Health Subaccount-- to draw down federal matching dollars. Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County Mental Health Plans provided a 46 percent match while the state provided a 54 percent match.

The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index for medical services, and other relevant cost items.

The Administration proposes to reduce by $46 million ($23 million General Fund) the amount the state provides to the counties for Mental Health Managed Care. Both the short-term and long-term effect of this action is to cost shift mental health services more to the counties. This proposal continues the Administration's direction to substantially reduce General Fund support for mental health services, other than the State Hospitals. About $164 million (General Fund), or 34 percent of the General Fund, was reduced from community-based mental health services in the Budget Act of 2002.

The proposed reduction will likely result in County Mental Health Plans serving fewer individuals and having difficulty in meeting statutory and contractual responsibilities related to the provision of Mental Health Managed Care services.

In fact, the state and counties are having difficulty in presently meeting needs and requirements. As noted in the Independent Assessment of California's Mental Health Managed Care Program, prepared by the Department of Finance (May 2002 and released November 2002), the state needs to address numerous issues regarding client access to services, quality of services, performance outcome measures, and program management functions.

Another report—Psychiatric Hospital Beds in California: Reduced Numbers Create Potential Crisis (prepared by the California Institute for Mental Health, August 2001)--, discusses the significant shortfall of inpatient psychiatric beds in California, as well as the lack of adequate capacity of the existing mental health system to provide alternative care for those clients in need of urgent care.

With respect to alternatives, there may be opportunities to obtain additional federal funds. First, the DMH could be directed to analyze the feasibility of expanding California's Home and Community-Based Waiver to include mental health services. Chapter 887, Statutes of 2002 (SB 1911, Ortiz), directed the DMH to conduct this analysis contingent on receipt of funding for this purpose. However given this fiscal environment, the DMH should be proceeding with this anyway.

Second, the DMH should also investigate whether California can obtain additional federal funds through the Medicaid Rehabilitation Option. Under this federal option, implemented in 1993, California has been able to draw down hundreds of millions in increased federal reimbursement. It is likely that some existing services could be included in this option in order to draw down additional federal funds.

2. Second Level Treatment Authorization Request Appeals. The Administration proposes to eliminate the second level Treatment Authorization Request (TAR) appeals process for savings of $126,000 (General Fund) in 2003-04. The savings comes from the elimination of two state positions. No trailer bill language has been proposed for this action.

Existing state regulation (Title 9, Section 1850.305) provides that a psychiatric hospital may file a second level TAR appeal when payment issues have not been resolved at the first level appeal (between the hospital and a County Mental Health Plan).

Typically, a second level TAR appeal involves disagreements between a hospital (non-county owned or operated facility) and a County Mental Health Plan regarding the number of bed days the county will reimburse.

For example, a hospital claims 15 days of inpatient services for a particular client and the County Mental Health Plan will only approve 10 days. As such, the hospital appeals the additional 5 days to the state. The state can either agree or disagree with the hospital. According to DMH statistics, the DMH agrees with County Mental Health Plans about 88 percent of the time.

It should also be noted, that the DMH's role in the second level TAR appeals process has inserted the department into judicial disputes between hospitals and County Mental Health Plans. According to the DMH, 29 lawsuits have been filed in this area.

The proposal continues the Administration's direction to further reduce the state's role in providing oversight of mental health services. In this case, oversight of inpatient hospital psychiatric services.

County Mental Health Plans are concerned about this proposal because hospitals who want to appeal a County Mental Health Plan denial of payment can go directly to the courts, and the DMH would no longer be involved in the case.

This is really a policy area that needs to be clarified more, rather than a fiscal, budgetary issue. Broader policy issues exist that affect the provision of inpatient psychiatric services and the payment for them.

With respect to the fiscal issue, the hospitals and/or County Mental Health Plans could reimburse the state for the workload associated with the two positions currently used by the DMH.

Highlights for the State Hospitals and State Support

The budget proposes expenditures of $660.4 million ($513.4 million General Fund) for the State Hospitals for a *net* increase of almost $15.4 million (increase of $18 million General Fund and decrease of $2.6 million in County Realignment Funds) over the revised 2002-03 budget.

Further, an appropriation of $21.5 million ($736,000 General Fund and $20.8 million Public Building Construction Fund) is provided for capital outlay purposes.

Major budget proposals are as follows:

- Proposes an augmentation of over $3.5 million (General Fund) and 47 positions to continue activation activities associated with the secure treatment facility at Coalinga.

- Increases by $3.7 million (General Fund) to reflect half-year funding for level-of-care staff and operating expenses to fund an increase of 94 penal code beds.
- Increases by $2.3 million (General Fund) and 31 positions to fund an increase of 27 beds for Mentally Disordered Offenders.
- Provides $11.4 million ($9.5 million General Fund and $1.9 million in Realignment Funds) for operating expense increases in the areas of outside medical care, food and pharmaceuticals.
- Requests $3.5 million (Reimbursements) and 50 positions from the California Youth Authority for the operation of a 20-bed correctional treatment center serving wards who require an intermediate level of inpatient mental health care. The program will operate under the acute psychiatric license of Metropolitan State Hospital, but will be physically located within the Southern Youth Correction Reception Center and Clinic (CYA facility).
- Provides $16.9 million (Public Building Construction Fund) for the purchase of equipment for Coalinga State Hospital. All areas of hospital operations are represented in this request, including the health care clinic, automotive maintenance, information processing systems, hospital police, surgery suite, and dining areas.
- Provides $832,000 (Public Building Construction Fund) for preliminary plans to construct a new kitchen facility and renovate all existing seven satellite kitchens and dining facilities at Metropolitan State Hospital.
- Increases by $7.6 million (Public Building Construction Fund) for the construction phase of a project to provide fire, life and safety modifications at Patton State Hospital.
- Proposes $3.4 million (Public Building Construction Fund) to upgrade the electrical system at Patton State Hospital.